VERITA

INVESTIGATIONS - REVIEWS - INQUIRIES

An investigation into the quality of care and treatment of patients at Fordingbridge Hospital

A report for
Hampshire Primary Care Trust

August 2008

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Verita is an independent consultancy which specialises in conducting and managing inquiries, investigations and reviews for public sector and statutory organisations.

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1. Introduction

1.1 Ford Ward at Fordingbridge Hospital is a self-contained, purpose-built rehabilitation and palliative care unit. It is on the site of older hospital buildings that now accommodate certain out-patient services, including x-ray and podiatry, a GP surgery and an out-of-hours GP service. The hospital is now managed by Hampshire Primary Care Trust ("the trust"). This report uses the name Fordingbridge Hospital to refer specifically to the rehabilitation and palliative care unit.

1.2 In November 2007 the trust asked Verita to manage and conduct an independent investigation into continuing concerns about poor quality nursing care and treatment of patients on Ford Ward at F'ordingbridge Hospital.

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Also at this time, a coroner's inquest into the death of a patient made criticisms of the standard of the documentation of patient care at the hospital.

1.4 In June 2004 the ward manager reported difficulties she was having in getting ward staff to accept the changes to procedures and practice she wanted to introduce. Furthermore, audit reports identified concerns relating to clinical care skills, standards of communication and an underlying theme of negative attitude and culture among nursing staff.

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Further concerns about the standards of nursing practice and care were raised as part of this disciplinary investigation.

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1.7 In 2005 Margaret Buttergieg, an independent consultant, was commissioned to investigate the future development needs of staff working in the community hospitals in the New Forest. She identified a number of concerns in relation to the staffing arrangements, including leadership issues, practice issues and staff attitudes, particularly in relation to training and development. A further formal review of Fordingbridge Hospital was carried out at about this time.

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1.11 In light of continuing concerns the trust decided to suspend admissions to Fordingbridge Hospital until the independent investigation is completed.

1.12 Verita is a London-based management consultancy specialising in the management and conduct of investigations, reviews and inquiries.

1.13 Kate Lampard and Chris Brougham conducted the investigation. Kate Lampard is a qualified barrister and has chaired a strategic health authority and a mental

health trust. Chris Brougham is a former senior healthcare manager. Both have experience of carrying out investigations and reviews.

Approach

1.14 The investigation was conducted in private and the investigation team had access to documents and witnesses, but the investigation relied heavily on the testimony of witnesses. Much of what was said was subjective and in view of this we have relied only on comments that were supported by more than one person and that were generally held. We saw two letters of complaint about the care and treatment of patients received by the trust from patients' relatives. These letters are not included in the report because the complainants asked for anonymity. Appendix A lists the details of the individuals interviewed for the investigation and appendix B lists titles of current and previous staff. We followed good practice in the conduct of our work by, for example, allowing interviewees to be accompanied by a friend or union representative and giving them the opportunity to comment on the factual accuracy of the interview transcripts and giving the trust the opportunity to comment on the investigation report before publication. As the report relies heavily on the testimony of witnesses we have on occasions felt it necessary to quote verbatim what we were told to make clear the content of the comments received. The report also includes our findings, comments and analysis of what witnesses told us.

1.15 At the request of the trust, all staff referred to in this report are identified by their formal job title rather than by name. In certain places this inevitably makes the report less easy to read than would be the case otherwise.

2. Terms of reference

2.1 The terms of reference of the investigation are to:

1. Identify and assess as far as possible, against specific criteria, the prevailing organisational culture at Fordingbridge Hospital.

2. Establish the facts behind two specific allegations made in July 2007 by relatives of patients.

3. Establish the facts behind an allegation made by a patient in October 2007.

4. Review the previous investigations into earlier allegations of poor quality of care and treatment at the hospital (found to date from 2003 to 2006) to assess whether:

   they were systematic, transparent and robust and
   appropriate action was subsequently taken in the light of any findings and recommendations.

5. Highlight what, if any, organisational issues had a bearing on the issues identified.

6. Provide a written report to the chief executive of the PCT.

2.2 The investigation has no disciplinary remit, although the findings may inform the PCT as to whether disciplinary proceedings are appropriate.

3. Executive summary and recommendations

3.1 Ford Ward at Fordingbridge Hospital is a self-contained, purpose-built rehabilitation and palliative care unit. It is on the site of older hospital buildings that now accommodate some out-patient services, including x-ray and podiatry, a GP surgery and an out-of-hours GP service.

3.2 Fordingbridge Hospital used to come under the management of Salisbury Hospital, but on the establishment of PCTs in April 2002, responsibility for the hospital passed to New Forest Primary Care Trust (the "PCT"). In 2004 New Forest PCT, which was one of the smallest in the country, entered into an alliance, under a single management team, with the Eastleigh and Test Valley PCT. The two PCTs were known as the South West Hampshire PCTs Alliance. In October 2006 management of the hospital passed to the new Hampshire PCT ("the trust").

3.3 In November 2007 Hampshire PCT asked Verita to manage and conduct an independent investigation into continuing concerns about the quality of nursing care and treatment of patients on Ford Ward at Fordingbridge Hospital. These concerns led the trust to close the hospital to admissions in November 2007 until the independent investigation is completed.

3.4 Verita is a London-based management consultancy specialising in the management and conduct of investigations, reviews and inquiries.

3.5 Kate Lampard and Chris Brougham conducted the investigation. Kate Lampard is a barrister and has chaired a strategic health authority and a mental health trust. Chris Brougham is a former senior healthcare manager. Both have substantial experience of carrying out investigations and reviews.

3.6

Also at this time, a coroner's inquiry into the death of a patient made criticisms of the standard of the documentation of patient care at the hospital.

3.7 In June 20 4 the ward manager reported difficulties she was having in getting ward staff to 'accept the changes to procedures and practice that she wanted to introduce. Furthermore, audit reports identified concerns relating to clinical care skills, standards of communication and an underlying theme of negative attitude and culture among nursing staff.

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Further concerns about the standards of nursing practice and care were raised as part of the disciplinary investigation.

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3.10 Also In 2005, the PCT commissioned Margaret Buttergieg, an independent consultant, to investigate the future development needs of staff working in the community hospitals in the New Forest. She identified a number of concerns in relation to the staffing arrangements, including leadership issues, practice issues and staff attitudes, training and development. A further formal review was carried out around the time that Margaret Buttergieg reported to the PCT.

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Approach

3.14 The independent investigation was conducted in private and we had access to documents and witnesses, but the investigation relied heavily on the testimony of witnesses. We followed good practice in the conduct of our work by, for example, allowing interviewees to be accompanied by a friend or union representative and giving them the opportunity to comment on the factual accuracy of the interview transcripts and giving the trust the opportunity to comment on the investigation report before presentation to the trust board.

3.15 The report includes our findings, comments on and analysis of what we were told by witnesses.

3.16 We consider the issues that arose about nursing care and the patient experience, medical care, the nursing team and contributory factors.

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3.18 In considering the issues that have arisen in relation to the culture and care of patients at Fordingbridge Hospital and in making judgments in respect of staff practices and behaviours, we have, where relevant, used the standards from the documents highlighted below as benchmarks of good practice:

Department of Health, Modernisation Agency: Essence of Care

- Nursing and midwifery Council: The NMC code of professional conduct and ethics
- Department of Health, National Patient Safety Agency: The Team Climate Assessment Measurement [TCAM] questionnaire.

Nursing care and the patient experience

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3.23 We asked staff about the training and development they had received to carry out their role. While mandatory training had been carried out, training in mental health had not taken place and some staff had not received training in palliative care.

The ward environment

3.24 The rehabilitation and palliative care unit at Fordingbridge Hospital is a light and airy building in good decorative order. There are however a number of matters relating to the building which undermine patient care. One of the issues is the lack of bell cords in the lounge. There is only one bell cord which is accessible, so in order to attract attention, patients are often reduced to banging on tables and shouting for help. This infringes the dignity of patients and does not meet the essence of care nursing standard on privacy and dignity.

3.25 The physical environment of the ward is not fit for purpose because the doors at either end of the ward have handles which are a simple turn mechanism, and the dayrooms have doors to the outside with no locks on them. None of the doors is alarmed. Staff told us that there had been cases of youths congregating in the hospital grounds and committing vandalism and the lack of security had made them feel vulnerable. They also described how they had constantly to keep an eye on patients in order to ensure that they did not wander out of the building.

Policy and practice

3.26 Changes in policy and practice have been introduced to Fordingbridge Hospital over time by each new manager. An example of this was the introduction of a new policy on visiting hours.

Staff attitude to patients and visitors

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This is unacceptable and needs to be addressed.

Medical care

3.29 Patients admitted to Fordingbridge Hospital come under the care of either the GP who admitted them, or under the care of one of two consultant physicians. The medical staff we interviewed told us that the medical cover arrangements were not satisfactory and that this could undermine the continuity of patient care. In addition, the senior house officers (SHOs) pointed out to us that as Southampton University Hospital NHS Trust employees they could not access x-ray and blood test results for patients at Fordingbridge Hospital because these tests are undertaken at Salisbury Hospital or at PCT facilities which are on a separate IT system. This meant that the SHOs had to rely on the clerical staff at Fordingbridge Hospital to access results for them.

3.30 The SHOs told us that they had had no induction to the ward at Fordingbridge Hospital or the policies and procedures of the ward.

The nursing team

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Ward sister

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Contributory factors

3.36 There has been a succession of managers appointed to oversee or play a part in the management and development of Fordingbridge Hospital over the last few years.

3.37 There is evidence of confusion within the management teams and among nursing staff as to the respective roles of managers in relation to the hospital. There is evidence of inadequacies in the lines of accountability. For instance, the PCT's professional development facilitator was asked to go to Fordingbridge Hospital in the autumn of 2005 to undertake professional development work, but until the

appointment of a ward manager six weeks later, she appeared to be the manager there although that fact was not formally recognised.

3.38 At a later stage, the ward sister and the rest of the nursing staff clearly thought that the trust's head of clinical leadership had assumed the role of ward manager at the hospital. The head of clinical leadership denied ever being the ward manager.

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Professional nursing

3.40 We were told that the trust had set up a monthly open forum for clinical professionals to receive information regarding national and local policy, a managers' network, and a clinical professionals group which considered contributions from various groups of staff in relation to clinical decision making.

There is no systematic arrangement in place for staff to receive clinical information and updates and a lack of clinical supervision.

Clinical governance

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HR issues

3.42 There are a number of concerns regarding the handling of relations with employees at Fordingbridge Hospital. These include past instances of the PCT failing to take appropriate action to discipline staff, or pursuing disciplinary proceedings inappropriately.

These shortcomings have highlighted a number of concerns about the trust's policies, capacity and capability in relation to employment issues.

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Recommendations

R1 The delivery of nursing care should be organised to ensure that patients are at all times supervised appropriately in the dayroom.

R2 The trust should ensure that Fordingbridge Hospital is able to provide palliative care to a standard that meets good practice guidance.

R3 A review of Fordingbridge Hospital should be carried out to agree the type and range of services that will be provided there.

R4 A skill, grade and gender mix review should be carried out.

R5 Staff based at Fordingbridge Hospital should receive appropriate training and development to be able to fulfil their roles.

R6 A patient information leaflet should be developed which includes information on visiting times, other ward information, treatment procedures and ways in which patients can be involved in their care.

R7 Nursing care should be organised (whether that is team nursing, primary nursing or otherwise) to deliver individualised care.

R8 Care plans, even if these are based on core care plans should be individualised to meet the needs and, so far as is possible, to meet the preferences of each patient.

R9 Care plans must cover all aspects of care including a patient's physical, psychological and social needs and as necessary, detailed issues such as falls, MRSA and hydration.

R10 Care plans should be kept up-to-date, regularly reviewed and used as a live document to inform patient care.

R11 The trust should ensure that the physical environment at Fordingbridge Hospital is fit for purpose by ensuring that there is an appropriate system in place to allow patients to call for assistance and by reviewing the security of all doors to ensure that patients are safe from wandering and that patients and staff are safe from intruders.

R12 The trust should ensure that managers, in consultation with nursing staff, review the arrangements with regard to the use of commodes, whiteboards and visiting hours to ensure that they are workable and appropriate.

R13 There should be a review of the policy for the locking of doors at Fordingbridge Hospital.

R14 Nursing staff should be reminded on a regular basis at ward meetings, professional nursing meetings and via internal bulletins of the need to treat patients and visitors with dignity and respect and that the failure to do so will be treated as a serious matter of misconduct.

R15 The trust should ensure that there is an effective and widely understood whistle-blowing policy and that a failure to treat patients or visitors with dignity or respect should be reported under that policy if the usual ways of reporting concerns are not available.

R16 Qualified nursing staff should be reminded on a regular basis of their obligations under the NMC professional code of conduct, including the provisions requiring them to:

act in such a way that justifies the trust and confidence that the public has in them and

recognise and respect the role of patients as partners in their care and the contribution that they can make to it.

R17 The trust should review medical cover at Fordingbridge Hospital (including the issue of doctors' access to patient records and test results, and the arrangements for

the induction of temporary medical staff) to ensure that there is appropriate continuity of medical cover and ongoing patient care.

R18 The trust must ensure that there is a robust system of annual appraisal of all staff, including training and development needs and that there is a trust-wide system for auditing and monitoring compliance.

R19 Managers should ensure that as part of the appraisal, training and development systems, attention is paid to the need for all staff to be part of a system of internal rotation and to take up secondments.

R20 The trust should ensure that there is an effective and widely understood whistle-blowing policy and that failure to treat other members of staff in an appropriate manner should be reported under that policy if the usual ways of reporting concerns such as this are not available.

R21 Qualified nursing staff should be reminded via ward meetings, professional nursing meetings and via internal bulletins of their obligations under the NMC professional code of conduct, including the provisions requiring them:

to work co-operatively within teams and to respect the skills, expertise and contribution of colleagues, and to treat colleagues fairly and without discrimination and

to work with other members of the team to promote healthcare environments that are conducive to safe therapeutic and ethical practice.

R22 The trust should ensure that at all times the hospital has strong professional leadership from a full-time ward manager with the support of a full-time deputy manager and that both are suitably trained and developed in order to fulfil their roles.

R23 Ward sisters and managers should have a clear line of accountability and be offered support in their roles both professionally and managerially by an identified and readily accessible line manager.

R24 Staff should have the opportunity to attend ward meetings on a regular basis to learn about management issues and to contribute to decision making about how new nursing practices will be introduced, managed and delivered.

R25 An up-to-date nursing strategy needs to be developed which includes the structure for clinical supervision, professional nursing networks, dissemination of national and local initiatives and developments in practice.

R26 There needs to be a trust-wide system in place to ensure that the staff have the opportunity to learn from incidents within the ward, across the trust and in the NHS generally.

R27 The trust needs to review its capacity and capability to manage HR processes including disciplinary and performance issues.

R28 The trust needs to ensure that there are agreed policies and procedures for taking forward performance and disciplinary matters including where responsibility for administration and decision making in respect of those matters is to lie.

R29 Line managers should receive training and development so they are clear about their roles, responsibilities and legal obligations in relation to performance and disciplinary matters.

PART ONE - BACKGROUND OF THE INVESTIGATION

4. Fordingbridge Hospital

4.1 Ford Ward at Fordingbridge Hospital is a self-contained, purpose-built rehabilitation and palliative care unit. It is on the site of older hospital buildings that now accommodate outpatient services, including x-ray and podiatry, a GP surgery and an out-of-hours GP service. This report uses the name Fordingbridge Hospital to refer specifically to the rehabilitation and palliative care unit.

4.2 Until July 2005, when bed numbers were reduced to about 20, Fordingbridge Hospital had approximately 31 beds. Half the beds at the hospital are for consultant admissions and the other half are for patients admitted by GP's in Fordingbridge, Ringwood and Ashley Heath.

4.3 Most of the accommodation at Fordingbridge Hospital is arranged off a central corridor. At the top of the corridor are a number of offices, including the nurses' office. There are four open bed bays down one side of the corridor and then a large dayroom. A door at the bottom of the corridor, leads to a hospital car park. On the other side of the corridor, opposite the dayroom, are an exercise and assessment room and some offices used by the physiotherapy and other staff attached to the locality community rehabilitation team ("CRT"). Opposite the bed bays, are service rooms and bathrooms. The nurses' station is in the corridor. A side corridor runs off from the top of the main corridor. A number of single rooms open into it. These are principally used to accommodate palliative care patients. At the end of the side corridor there is another large dayroom. A plan of Fordingbridge Hospital is at appendix C.

5. The recent history of Fordingbridge Hospital

5.1 We set out here what we have ascertained both from the documents supplied to us and from our interviews with staff and other interested parties about the recent history of Fordingbridge Hospital. We highlight, in particular, matters and events that relate to the culture and standards of care at the hospital.

5.2 Fordingbridge Hospital used to come under the management of Salisbury Hospital, but on the establishment of PCTs in April 2002, responsibility for it passed to New Forest Primary Care Trust ("the PCT"). In 2004 New Forest PCT, which was one of the smallest in the country and was experiencing significant financial pressures, entered into an alliance, under a single management team, with the Eastleigh and Test Valley PCT. The two PCTs were known as the South West Hampshire PCTs Alliance. In October 2006 management of the hospital passed to the new Hampshire PCT ("the trust").

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5.7 On 22 July 2005 a meeting was held between the then director of adult services - Hampshire west, the lead manager for intermediate care, the joint director of nursing, and the HR manager. The notes of that meeting detail concerns about the standards of nursing practice and care at Fordingbridge Hospital.

The notes of the meeting on 22 July 2005 record that the meeting agreed:

c

a risk assessment, would be undertaken of the staffing situation and patient dependency to identify whether to transfer patients to other facilities
senior staff would be transferred to Fordingbridge to stabilise the staffing situation...

the number of patients would be reduced from the current 23 to 20 and that a decision would be made about whether it was possible to do this through planned discharges

that the GPs, Consultant and staff grade would be advised of the situation

that a formal review would be instigated with an external assessor

directors, on-call managers, immediate managers and the League of Friends Chairman would be advised that there were sufficient concerns to instigate a formal review

- *the report being prepared by Margaret Buttergieg would be obtained and the status of this report checked."*

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5.9 Margaret Buttergieg, the independent consultant referred to in the notes of the meeting of 22 July 2005, was commissioned to investigate the future development needs of staff in the community hospitals in the New Forest. Her report for the South West Hampshire PCTs Alliance is dated August 2005. It includes information she had gathered on staffing and other matters relating to Fordingbridge Hospital. She identified concerns about staffing arrangements, including leadership issues, practice issues and staff attitudes, particularly in relation to training and development.

5.10 In response to the agreement made at the meeting held on 22 July 2005 to instigate a *"formal review"* into Fordingbridge Hospital, the PCT commissioned Loretta Kinsella, divisional senior nurse for surgical services at Portsmouth Hospital NHS Trust, to undertake an investigation and report back to the PCT. Her report shows that the investigation was largely based on staff interviews using a standard format of specific

questions. The report includes a brief summary of the findings of the investigation in the following terms:

> *"This investigation has identified that there are processes in place which guide delivery of fundamental nursing care. The staff interviewed consistently demonstrated how nursing care is delivered. The majority of staff were able to demonstrate the rationale for care and recognised their responsibility in providing safe quality care. However, the investigation revealed a lack of senior nursing leadership and a distinct lack of governance structures."*

The report goes on:

> *"The following recommendations suggest a series of actions, which if implemented will provide the assurance sought by New Forest PCT."*

5.11 But the copy we have seen does not include the recommendations made by Loretta Kinsella and no one that we interviewed was able to tell us what action plan, if any, was drawn up in response to her report.

5.12

No appointment was ever made to replace the F grade ward sister who had retired. No permanent, full-time appointment to the G grade ward manager post at Fordingbridge Hospital was made until shortly before the hospital closed to new admissions at the end of October 2007. The HR manager with responsibility for West Hampshire ("the HR manager", told the investigation team that because of New Forest PCT's significant financial difficulties there was a recruitment freeze during 2005 and 2006. We do not know whether that recruitment freeze was the reason for the PCT not appointing a further F grade ward sister or a permanent G grade ward manager.

5.13 From about the autumn of 2004 until October 2006, there was an H grade modern matron in post with responsibility for a number of the community hospitals in

the New Forest including Fordingbridge Hospital ("the modern matron"). We understand that she was based first at Lymington Hospital and later at Fenwick Hospital. A number of staff we interviewed told us that, following the departure of the ward manager, they considered the modern matron to be responsible for managing the ward. Towards the end of 2005, the G grade leader of the CRT ("the CRT leader") based at Fordingbridge Hospital, was asked to assume some responsibility for overseeing the in-patient ward as well. There was general confusion among PCT managers and staff about the extent of the CRT leader's role in relation to the ward and what responsibility if any, she had for line managing the ward sister.

5.14 At about the same time as the CRT leader was asked to become involved in managing the ward, the professional development facilitator, who had previously been a rehabilitation team manager in the PCT, was asked by the modern matron to undertake professional development at Fordingbridge Hospital. The PCT also employed the consultant nurse for older people at Southampton University Hospital NHS Trust, ("the nurse consultant") to undertake professional advice and consultancy work at Fordingbridge Hospital for two days a week.

5.15 The professional development facilitator, the nurse consultant, the modern matron and the site services manager for Fordingbridge Hospital formed a development action group to consider and take forward the development needs of the hospital. The action plan devised by that group, and dated 2 December 2005, identifies a wide range of issues as needing to be tackled. These include:

"customer relationship training
ID badges to be worn at all times

- *letter to be circulated re not eating patient's food*
- *answer call bells promptly*
- *supervision of patients*
- *training programme*
- *training needs analysis*

evidence that all patients are involved in care planning
incident trends."

5.1 6 As we set out in part two of this report, our investigations show that nearly all of these matters continued to present a problem at Fordingbridge Hospital up until the time of the decision to close the hospital to further admissions in October 2007.

5.1 7 The nurse consultant explained that is was clear from Margaret Buttergieg's report, that much work was needed with staff at Fordingbridge Hospital in particular on basic matters such as staff roles, responsibilities and accountabilities, policy drivers within the health service and communication and interpersonal skills. To meet this need a small working group, which included representatives from the HR and training department, the nurse consultant, the professional development facilitator and the then lead nurse for the South West Hampshire PCTs alliance, now called the head of clinical leadership (west) ("the head of clinical leadership") devised a two and a half day training programme called the Clinical Foundation Programme for staff to attend as a team. That programme was introduced for staff at Fordingbridge Hospital in January 2006 and was later rolled out to the rest of the PCT. We were told that the programme was well attended and many of the staff that we interviewed described their experience of it in positive terms.

5.18 The response to the introduction of the Clinical Foundation Programme appears for the most part to have been positive, but the nurse consultant and the professional development facilitator told us that other efforts to innovate or to improve patient care and nursing practice at Fordingbridge Hospital were less well received. In some instances they were undermined or wholly ignored. •

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5.20 Both the nurse consultant and the professional development facilitator told us that they felt that the relevant line managers lacked the commitment or support that was required to drive through necessary development action and failed to take disciplinary action when necessary.

5.21 In late summer of 2006, the nurse consultant moved on from her work with Fordingbridge Hospital. The professional development facilitator left in November 2006. By then the modern matron had also left her post.

5.22 Towards the end of January 2007, the area director for Hampshire west met with the head of clinical leadership. They agreed that there was a need for the head of clinical leadership to devote particular attention to Fordingbridge Hospital. From about mid-February 2007, the head of clinical leadership went to Fordingbridge Hospital every week. It soon became clear to her that Fordingbridge Hospital needed to be her main priority.

5.23 Accordingly, from about March 2007, the head of clinical leadership went to Fordingbridge Hospital about twice a week. If she was unable to do so she would discuss matters with the ward sister by phone.

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5.25 We saw internal documentation which demonstrated that, following an earlier complaint about the treatment of a patient, the trust's clinical audit facilitator, attended at Fordingbridge Hospital on 11 May 2007 and undertook a series of interviews with staff and patients. Her summary of those interviews shows that patients commented on what they felt was the short staffing on the ward.

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5.28 In May 2007 the trust appointed a new head of adult services in west Hampshire ("the head of adult services"). She had responsibility for the management of Fordingbridge Hospital and tine management responsibility for the head of clinical leadership. On 18 July 2007 the head of adult services called a meeting of the staff at the hospital. Notes of the meeting show that at that meeting she informed the staff about the recent complaints and told them that an independent investigation would be

undertaken. Staff have told us that the letters of complaint had been read out but they were not given copies. Staff had also been informed that the head of clinical leadership was to be based at Fordingbridge Hospital and would be spending more time there and that efforts to appoint a permanent ward manager were continuing.

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5.32 In August 2007 an interim director of operations for care services across Hampshire was appointed ("the director of operations"). She assumed direct line management of the head of adult services.

5.33 The head of clinical leadership told us that in September 2007 she started working full-time in order to give the extra hours she needed to spend at Fordingbridge Hospital and *"pick up the management role".* She made it clear to us that she was riot acting as the ward manager but rather as a service manager. She conceded however that the staff had probably always seen her as the ward manager. She told us:

5.34 We understand from the head of adult services that the permanent ward manager post was advertised three times and an appointment was eventually made in or about September 2007 but the appointee was not released to start work by her employer until the end of October 2007.

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The director of operations told us this complaint compounded her pre-existing concerns about the environment and culture at Fordingbridge Hospital and prompted her to seek the trust board's agreement to the temporary suspension of admissions to the ward. The hospital stopped accepting new admissions in mid October 2007 and the last patient was discharged on 27 November 2007.

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5.38 The consultant nurse who had been asked to act as the investigating officer in respect of the complaints made about the treatment of presented a report in early November 2007 in which she points out that it was produced in haste in

order to inform the independent investigation team which had been appointed on or about 31 October 2007.

PART TWO - FINDINGS, ANALYSIS AND COMMENT

6. Introduction

6.1 In this part of our report we analyse the issues relating to the organisational culture and the standards of care and treatment of patients at Fordingbridge Hospital. We will consider those issues under the following headings:

Nursing care and the patient experience
Medical care
The nursing team
Contributory factors.

6.2 We then examine the facts surrounding the specific complaints the trust received on 12 July 2007, referred to at paragraph 5.27 above, and the complaint received on or about 9 October 2007, referred to at paragraph 5.35 above, and our findings in relation to those specific complaints.

6.3 In considering the issues arising in relation to the culture and care of patients at Fordingbridge Hospital and in making judgments in respect of staff practices and behaviours, we have used the standards from the documents highlighted below as benchmarks of good practice where relevant.

Department of Health, Modernisation Agency: Essence of Care
Nursing and Midwifery Council: The NMC code of professional conduct and ethics
Department of Health, National Patient Safety Agency: The Team Climate Assessment Measurement [TCAM] questionnaire.

7. Nursing care and the patient experience

The supervision of patients

7.1 It is clear from the matters we record in part one of this report, that the issue of the supervision of patients at Fordingbridge Hospital has been a matter of concern and the subject of complaint for some time.

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7.3 Once patients are up in the morning, we were told that most of them are taken down to the main dayroom where they remain until bedtime.

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7.7 We accept that there may be occasions when the nursing staff find it difficult for unavoidable reasons to supervise or interact with patients to the extent that might be desirable, but the evidence shows staff consistently being reluctant to spend time with their patients and being content to allow them to remain unsupervised in the dayroom for long periods. We believe that even when summoned to assist a patient, there are occasions when the nursing staff do not respond as promptly as they should. This happens particularly if the nurses are summoned at a time when they are taking a break together. The evidence that the investigation team has received on this matter, both from written complaints, as well as oral evidence, including from the nursing staff themselves, is supported by what we observed when we visited Fordingbridge Hospital at the beginning of November 2007. When we arrived at the hospital we found three or four patients sitting in the dayroom, not engaged in any activity of any kind, and two trained nurses sitting down at the nursing station, out of sight of the dayroom, chatting among themselves.

7.8 The problem of patients in the dayroom being unable to attract the attention of staff is exacerbated by the inadequate bell mechanism there. We deal with that issue in the section on the physical environment of the ward at paragraph 7.21 below.

Recommendation

R1 The delivery of nursing care should be organised to ensure that patients are at all times supervised appropriately in the dayroom.

The lack of individualised care and core planning

7.9 The care a patient receives at Fordingbridge Hospital is based upon a standardised core care plan. There have been a number of attempts in the past to improve the quality of care planning and in particular to ensure that the core care plans are sufficiently tailored to the needs of individual patients. When asked about care planning by the investigation team, staff were anxious to tell us that care plans were based around individual patient needs and that patients were consulted as far as possible about their personal preferences for their care and treatment. It was noticeable however that few, if any, meaningful examples of the individualising of care were given and many staff did not appear to understand the importance of ensuring that care was tailored to the particular needs and preferences of the individual. There was no suggestion that the agreement and monitoring of personal goals for patients plays any significant part in the care planning process.

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7.11 We were concerned about the extent to which care planning is reviewed, kept up-to-date and truly informs and prescribes the care that is given.

7.12 It was explained to us that some time ago the nurses introduced a system whereby handovers between shifts were conducted using a single "handover sheet" which contains information, including the name, age, doctor, diagnosis and an update on all the patients on the ward.

she:

7.13 The staff that we interviewed confirmed that handovers took place in the nurses' office without reference to the care plans. They also confirmed that there was no occasion on which the nursing team took the opportunity in a systematic way to review, reflect on and, if necessary, amend the care plans.

7.14

7.15 Another concern that we have about the standard of care at Fordingbridge Hospital is the extent to which patients are offered choices about their care and have their preferences respected.

We also discovered that the dayroom at the top of the ward had been taken out of use to provide further staff accommodation. This meant that patients did not have an alternative quiet place if they wanted to get away from the noise of the television and other distractions in the main dayroom.

All these examples we have given of the lack of patient choice also undermine and fail to promote patient privacy and dignity as envisaged in the Essence of Care and the NMC Code of Conduct.

7.16 We were told that many patients at Fordingbridge Hospital suffered from confusion and have mental health problems. None of the staff we interviewed had undergone any mental health training and few had received training on how to deal

with difficult patients. Furthermore, although the hospital admits palliative care patients, only a few of the staff have received training in this area and that appears to have amounted to limited, day or half-day sessions run by nurses at Salisbury Hospice.

7.17 When we discussed with the staff the palliative care that the hospital is able to provide, they expressed their belief that the hospital could not offer the same standards of care as a hospice because it has much tower staffing ratios. We have not examined in detail the issue of staffing levels at the hospital and we are therefore unable to comment on the appropriateness or otherwise of the staffing levels for the provision of palliative care.

Recommendation

R2 The trust should ensure that Fordingbridge Hospital is able to provide palliative care to a standard that meets good practice guidance.

7.18 Even if staffing levels do hamper hospital staff in their efforts to provide palliative care, we received evidence to suggest that some of the nursing staff used the issue as a blanket excuse for any failings. They did not question whether the nature and quality of their interactions with patients had also served to undermine the patient experience.

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7.20 In order to offer individualised care, the trust needs to be dear about the purpose and range of services that can be provided at Fordingbridge Hospital and there needs to be a commitment, in terms of leadership, staffing levels, training, patient information and other resources, to ensure that all patients accepted at the hospital receive the care and treatment that they need and that that care and treatment is of the highest possible quality.

Recommendations

R3 A review of Fordingbridge Hospital should be carried out to agree the type and range of services that will be provided there.

R4 A skill, grade and gender mix review should be carried out.

R5 Staff based at Fordingbridge Hospital should receive appropriate training and development to be able to fulfil their roles.

R6 A patient information leaflet should be developed which includes information on visiting times, other ward information, treatment procedures and ways in which patients can be involved in their care.

R7 Nursing care should be organised (whether that is team nursing, primary nursing or otherwise) to deliver individualised care.

R8 Care plans, even if these are based on core care plans, should be individualised to meet the needs and, so far as is possible, to meet the preferences of each patient.

R9 Care plans must cover all aspects of care including a patient's physical, psychological and social needs and as necessary, detailed issues such as falls, MRSA and hydration.

R10 Care plans should be kept up-to-date, regularly reviewed and used as a live document to inform patient care.

The ward environment

7.21 The rehabilitation and palliative care unit at Fordingbridge Hospital is a light and airy building in good decorative order. It is in a pleasant location with views of trees and grass and has a small area outside where patients can sit in warmer weather. Our observations suggested that the housekeeping staff do a first-rate job of keeping the ward clean and tidy.

There are however a number of matters relating to the building which undermine patient care. One is the issue, which we have already dealt with under paragraph 7.15 above, of there being no alternative quiet room for patients to use if they do not wish to be in the dayroom. We are also particularly concerned about the inadequate bell system in the main dayroom.

This infringes the dignity of patients and does not meet the essence of care nursing standard on privacy and dignity.

7.22 The doors of the unit are not fit for purpose. We were told that the locks on the main doors at either end of the ward were inadequate, being a simple turn mechanism, and that the dayrooms have doors to the outside with no locks on them at all. None of the doors are alarmed.

We understand from the ward manager and others that the matters of the bell system and the door locks have been highlighted as problems for many years but requests that they be dealt with have not been acted upon.

7.23 For a long time the ward was without a permanent ward clerk. The present incumbent was appointed in or about June 2007. She estimated that prior to her appointment there had been no permanent ward clerk for about two years but there

had been some temporary cover. The lack of a clerk dearly made the ward more difficult to run and placed a burden on the nursing staff and distracted them from their core duties: one of them referred to the staff becoming *"receptionists".*

Recommendation

R11 The trust should ensure that the physical environment at Fordingbridge Hospital is fit for purpose by ensuring that there is an appropriate system in place to allow patients to call for assistance and by reviewing the security of all doors to ensure that patients are safe from wandering and that patients and staff are safe from intruders.

Policy and practice issues

7.24 As we explain elsewhere, there have been many changes in the personnel involved in managing Fordingbridge Hospital over the last few years. Each manager has tried to introduce what they perceive to be necessary changes to practices on the ward. In a number of cases these changes appear to have been introduced without full regard for their implications in relation to patient care. Furthermore, they appear to have been introduced in a hurry without consulting staff or giving them an adequate explanation for their introduction.

7.25 We understand that at some point the professional development facilitator determined that staff should not use the whiteboards above patients' beds to record patient information, other than the patient's name and doctor, because the use of the boards breached patient confidentially. However physiotherapy staff explained to us that it was sometimes important to use the whiteboards to alert all staff to instructions for handling certain patients and as a result some staff continued to write instructions on them.

7.26 The modern matron decided while she was responsible for Fordingbridge Hospital that all patients, other than those who were immobile, must be made to walk to the toilet. In keeping with this policy change, most of the commodes on the ward

were removed.

7.27 Staff have explained to us that in practice they could not make all patients go to the toilet, especially at night time, and also complained that in any event they had too few commodes to deal with patients who really needed them.

7.28 We also heard about changes introduced to visiting hours which were reduced so that visitors were not on the ward during mealtimes. The justification for this was that the presence of visitors on the ward inhibited some patients from eating. There have also been problems with visitors eating patients' meals. At a meeting held on 18 July 2007 referred to above, the head of clinical leadership told staff that the ward was to be open to visitors from 11.30am until 8pm. Some staff were not happy with this arrangement and felt aggrieved that it was introduced without consultation with them.

7.29 Whatever the merits or otherwise of these changes in policy and practice, it seems that they may have been introduced without full consideration of their practical implications. The failure to consult staff or to explain the reasoning behind these changes in policy and procedure has caused unnecessary disaffection.

Recommendation

R12 The trust should ensure that managers, in consultation with nursing staff, review the arrangements with regard to the use of commodes, whiteboards and visiting hours to ensure that they are workable and appropriate.

7.30 We have been told that doors to the ward were sometimes locked to prevent confused patients from wandering out of the building. We were told of one occasion when the doors had been locked to prevent a confused relative from gaining access to the building. Night staff also told us that they routinely lock the doors at the beginning of their shift. None of the staff that we interviewed were aware of an agreed policy, written or otherwise, on the locking of doors.

Recommendation

R13 There should be a review of the policy for the locking of doors at Fordingbridge Hospital.

Staff attitude to patients and visitors

7.31 Many of the people that we interviewed, including members of the nursing staff, suggested to us that on occasions had been witnessed speaking to patients and visitors in an abrupt and aggressive manner. We have also heard of being observed on a number of occasions shouting at, intimidating and being deliberately rude to both patients and visitors. These incidents, however infrequent they may have been, amounted to a breach of the NMC code of professional conduct and are wholly unacceptable, taking an overall view, we have not been given the impression that staff as a whole systematically Mistreated patients or are either routinely or deliberately unkind, malevolent, or offensive towards patients and their visitors.

7.32 We do however believe that there is a culture at Fordingbridge Hospital in which staff can be casual, thoughtless, off-hand and lacking in self-awareness both as to their practices and their interactions with their patients.

7.33 We believe that the tack of supervision of patients, which we consider elsewhere, is also a manifestation of the casual and insensitive approach displayed by many of the nursing staff at Fordingbridge Hospital.

7.34 The poor attitude of staff is also reflected in the fact that, as the support staff told us, some staff often ordered food for patients which they intended to eat themselves.

7.35 The many instances of insensitivity, thoughtlessness and casualness on the part of staff that we heard about, and the general attitude of many staff are not in keeping with professional nursing standards and need to be addressed.

7.36 We asked those who told us of the particularly reprehensible behaviour on the part of one or two staff that we refer to in paragraph 7.31, whether they were aware of the trust's whistle blowing policy. Most of them said that they had not heard of it or

seen it. In any event, that policy was due for review in July 2007. So far as we are aware, that review has not taken place at the time of writing this report.

7.37 In light of these matters we make the following recommendations:

Recommendations

R14 Nursing staff should be reminded on a regular basis at ward meetings, professional nursing meetings and via internal bulletins of the need to treat patients and visitors with dignity and respect and that the failure to do so will be treated as a serious matter of misconduct.

R15 The trust should ensure that there is an effective and widely understood whistle-blowing policy and that a failure to treat patients or visitors with dignity or respect should be reported under that policy if the usual ways of reporting concerns are not available.

R16 Qualified nursing staff should be reminded on a regular basis of their obligations under the NMC professional code of conduct, including the provisions requiring them to:

> act in such a way that justifies the trust and confidence that the public has in them and
>
> recognise and respect the rote of patients as partners in their care and the contribution that they can make to it.

9. The nursing team

9.1 We looked in detail at the attributes, organisation and management of the nursing team at Fordingbridge Hospital. This has exposed a number of weaknesses. We believe many of the issues we raise and concerns we express elsewhere in this report about the standards of nursing care, the attitude of nursing staff and the patient experience are attributable to the weaknesses we have found within the nursing team and its management.

The make up and capabilities of the nursing team

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already discussed in paragraph 7.16 some of the deficiencies that we have ascertained in relation to staff training and skills. It is also worth noting that there is only one male nurse employed at Fordingbridge Hospital.

In the light of these matters we reiterate our recommendations R3, R4, and R5 and make the further recommendations below.

Recommendations

R18 The trust must ensure that there is a robust system of annual appraisal of all staff, including training and development needs and that there is a trust-wide system for auditing and monitoring compliance.

R19 Managers should ensure that as part of the appraisal, training and development systems, attention is paid to the need for all staff to be part of a system of internal rotation and to take up secondments.

The culture within the nursing team

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9.6 We are also concerned that the dynamic within the nursing team threatens its efficiency and, as a consequence, patient care.

9.7 Staff seemed to understand and accept that certain members of the team always worked the same shifts together and, once on the ward, worked as a team attending to particular patients at the same time. We believe these arrangements indicate a tendency for the interests and preferences of the staff to be put before those of the ward and patients on it.

Recommendations

R20 The trust should ensure that there is an effective and widely understood whistle-blowing policy and that failure to treat other members of staff in an appropriate manner should be reported under that policy if the usual ways of reporting concerns such as this are not available.

R21 Qualified nursing staff should be reminded via ward meetings, professional nursing meetings and via internal bulletins of their obligations under the NMC professional code of conduct, including the provisions requiring them:

to work co-operatively within teams and to respect the skills, expertise and contribution of colleagues, and to treat colleagues fairly and without discrimination and

to work with other members of the team to promote healthcare environments that are conducive to safe therapeutic and ethical practice.

The role of the ward sister

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9.11 From November 2005, for nearly two years, Fordingbridge Hospital was without a G grade ward manager.

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Recommendation

R22 The trust should ensure that at all times the hospital has strong professional leadership from a full-time ward manager with the support of a full-time deputy manager and that both are suitably trained and developed in order to fulfil their rotes.

10. Contributory factors

The management of Fordingbridge Hospital

10.1 It is apparent from the recent history of Fordingbridge Hospital set out above, that there has been a succession of managers appointed to oversee or play a part in the management and development of Fordingbridge Hospital over the last few years. We encountered some confusion among the nursing staff as to the respective roles and responsibilities of those managers.

10.2 There is also evidence of confusion in the management teams about their respective roles in relation to the hospital, and weaknesses in the system for managing and holding staff to account. The professional development facilitator was asked to go to Fordingbridge Hospital in autumn 2005 to undertake professional development work there.

10.3 The professional development manager also explained to us the difficulties she encountered because she had no real management authority even though she was supposed to be overseeing the development of Fordingbridge Hospital.

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10.4 This sentiment was echoed by other management staff who encountered problems in getting certain nurses to obey instructions and felt their efforts were undermined by not receiving the support of more senior staff.

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10.9 It is clear from the action plan that the head of clinical leadership developed for the ward, that she had identified many of the shortcomings that needed to be addressed and which feature in this report, including care planning, communication with staff, leadership issues, appraisal, training and development including secondment and rotation. However ward responsibility for these matters is recorded as being in the hands of the "ward manager". No one with appropriate skills was appointed to this post, so it was unlikely that many of the identified needs would be adequately dealt with.

10.10 The lack of clarity about the roles of managers, the failure to take up disciplinary issues, the long term absence of a senior ward manager and many of the other matters mentioned elsewhere in this report illustrate the poor management that, so far as we can tell, has been a feature of Fordingbridge Hospital for some time. Staff formed a view that there was an inadequate commitment by management. This caused widespread disaffection and disillusionment.

10.11 We were told that at one time there had been fairly regular ward management meetings where staff were offered the opportunity to consider with the ward manager matters relating to the operation, management and development of the ward. Staff said that such a meeting had not been held for some time. The head of clinical leadership on the other hand said that there had been about three staff meetings since January 2007 but she conceded that these had been unproductive for two reasons.

We suggest that some of the aggression expressed at staff meetings was probably a consequence of the disaffection and disillusionment with management that we noted in our interviews with hospital staff.

10.12 We believe that as a matter of good management practice staff should have regular opportunity to meet with management to receive information about developments affecting their unit and the trust as a whole and to contribute to discussions about matters affecting their working lives and practices. Such a forum should also be used to explain and agree matters of policy and procedure in relation to nursing care, so as to avoid the confusion and widespread dissatisfaction that has arisen in relation to matters such as the use of commodes and whiteboards and visiting hours.

Recommendations

R23 Ward sisters and managers should have a clear line of accountability and be offered support in their roles both professionally and managerially by an identified and readily accessible line manager.

R24 Staff should have the opportunity to attend ward meetings on a regular basis to learn about management issues and to contribute to decision making about how new nursing practices will be introduced, managed and delivered.

Professional nursing

10.13 Towards the end of 2006, a document entitled the "Quality Indicators for Professional Leadership Action Plan" was drawn up for the South West Hampshire PCTs Alliance by, it seems, the head of clinical leadership and the then director of nursing. The document was prepared in response to the audits and reports that had been produced at that time in relation to Fordingbridge Hospital and elsewhere in the Hampshire area, as well as the PCTs' failure to meet some of the healthcare assurance standards in respect of clinical and professional leadership. The action plan identifies, among other matters, the need to develop communication networks and guidance for staff on national and local policy, co-ordination of the distribution of clinical information, regular clinical supervision of all staff, and clinical forums across sites to develop clinical engagement and communication. The head of clinical leadership told us how, in keeping with this agenda, she set up, on a trust-wide basis, a monthly open forum for clinical professionals to learn about national and local policy. She also set up a managers network and ran a clinical professionals group which considered contributions from various groups of staff in relation to clinical decision making.

10.14 The evidence we received suggested that all these initiatives yielded little in the way of practical engagement on clinical matters with the nursing staff at Fordingbridge Hospital, and had little influence on their day-to-day understanding and practice.

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10.16 We have also ascertained that there was no nursing network and a poor understanding among staff in relation to national and local policy. Although some of the staff had heard of the Essence of Care and had been offered training on it, many, particularly HCSWs suggested that they knew nothing about it. Staff were unable to suggest any other national policy documents that they were presently working to.

10.17 We would also point out that the workforce strategy for the trust that was supplied to us is a draft document dated August 2007 but refers to the achievement of certain milestones by April 2004. It is clearly a cut and paste reincarnation of earlier strategies.

Recommendation

R25 An up-to-date nursing strategy needs to be developed which includes the structure for clinical supervision, professional nursing networks, dissemination of national and local initiatives and developments in practice.

Clinical governance

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Recommendation

R26 There needs to be a trust-wide system in place to ensure that the staff have the opportunity to learn from incidents within the ward, across the trust and in the NHS generally.

HR issues

10.19 We came across a number of matters that have given us cause for concern in respect of the handling of relations with employees at Fordingbridge Hospital. We refer elsewhere to the failure to regularise arrangements when staff change roles and responsibilities and to ensure that staff are adequately trained and supported to perform new roles. We were made aware of a number of instances in the past of the management at Fordingbridge Hospital failing to take appropriate action to discipline staff, or pursuing disciplinary proceedings inappropriately. We were concerned too to be informed by the HR manager that there was no written policy for assessing and managing poor performance in respect of employees previously employed under the PCTs in the west of Hampshire.

10.20 We have also been made aware of significant shortcomings in the handling of the employment issues arising from the specific complaints received about patient care on 12 July 2007 and in early October 2007. These shortcomings have highlighted a number of areas of concern that the trust needs to address. They are:

- The need for agreed, comprehensive and appropriate trust-wide policies covering disciplinary and performance issues.
- Managers' lack of understanding of and adherence to correct employment processes and procedures.
- The lack of leadership and lack of clarity about roles and responsibilities in the handling of employment issues.

10.21 Finally, we have doubts about the capacity in the trust's HR team. The HR manager told us that there were two members of the operational HR team for west Hampshire and they had responsibility for all HR matters, other than recruiting and contracting, for a workforce amounting to a whole time equivalent of 1,242 and a headcount of 1,680.

11. Conclusion

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11.4 We believe that these problems of staff attitude and behaviour have been able to take hold because of management's failure over a long period to ensure clear, consistent and effective leadership of the hospital and its nursing staff. In particular, we believe that managers have not adequately supported those staff who have tried to implement improvements and have not acted appropriately in managing and holding staff to account for poor performance. Managers have not followed up and ensured the delivery of development and action plans indicated by previous investigations into the hospital. And there has been a failure to engage hospital staff in trust wide work for maintaining nursing standards and clinical governance.

Recommendations

R27 The trust needs to review its capacity and capability to manage HR processes including disciplinary and performance issues.

R28 The trust needs to ensure that there are agreed policies and procedures for taking forward performance and disciplinary matters including where responsibility for administration and decision making in respect of those matters is to lie.

R29 Line managers should receive training and development so they are clear about their roles, responsibilities and legal obligations in relation to performance and disciplinary matters.

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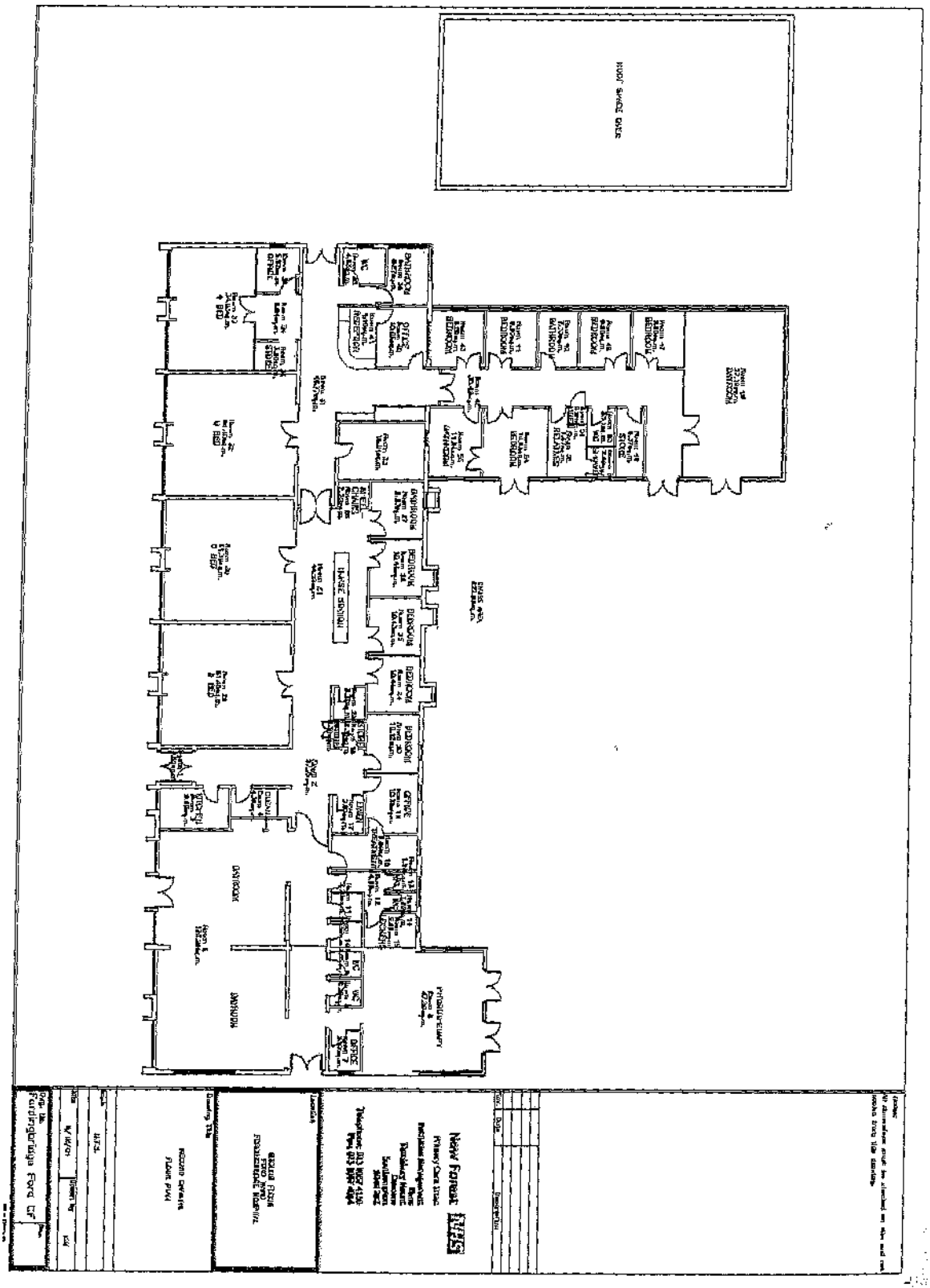
Appendix A

Appendix C

Plan of Fordingbridge Hospital



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Appendix D

List of national frameworks used as benchmarks of nursing practice and team culture

Department of Health, Modernisation Agency: Essence of Care

1. Privacy and dignity:
Benchmark: Patients are protected from unwarranted public view e.g. -use of screens, walls, clothes and covers.

2. Communication
Benchmark: Patients and carers experience effective communication sensitive to their individual needs and preferences, that promotes high quality care for the patient

3. Continence and Bladder and Bowel Care
Benchmark: Patients' bladder and bowel needs are met

4. Personal and Oral Hygiene
Benchmark: Patients personal and oral hygiene needs are met according to their individual and clinical needs

5. Food and Nutrition
Benchmark: Patients are enabled to eat and drink to meet their individual need

6. Privacy and Dignity
Benchmark: Patients feet that they matter all of the time and they are protected from unwarranted public view e.g. -use of screens, walls, clothes and covers.

Department of Health, National Patient Safety Agency: The Team Climate

Assessment Measurement [TCAM] questionnaire

Team working

Benchmark: The team works together cooperatively. The skills and contribution of each member is respected and the team are able to constructively challenge each other. The team are able to accept necessary changes in procedure. i.e. regular team meetings, supervision, taking time to consider how improvements can be made

Nursing and Midwifery Council: The NMC code of professional conduct and ethics

1. Nursing and Midwifery code of practice

- protect and support the health of individual patients and clients
- protect and support the health of the wider community
- act in such a way that justifies the trust and confidence the public have in you
  uphold and enhance the good reputation of the professions.