



# Learnings from Gosport

Sharing pharmacy themes, current practice &  
key resources

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# Background and context



- Gosport Independent Panel report published in June 2018
- Between 1989-2000 – concerns about opioid prescribing patterns
- An institutionalised regime of prescribing and administering “*dangerous doses*” of a hazardous combination of medication not clinically indicated or justified
- The lives of over 450 patients shortened as direct result, with a devastating impact on many families
- Patients and relatives powerless in their relationship with professional staff
- Government response published in November 2018

# Working together in pharmacy

**GPhC, RPS & APTUK have been working together to:**

- Bring together the key pharmacy themes from the report
- Look at current pharmacy practice and how things have changed
- Recap on the expectations on pharmacy professionals (pharmacists and pharmacy technicians) and systems
- Highlight key resources and other materials
- Develop a slide pack for pharmacy professionals to share and discuss, to encourage good practice and learning

# About these slides

- The slides emphasise that pharmacy practice has moved on significantly since the terrible events at Gosport
- They are designed as prompts for reflection and learning
- But, we must all continue to work together to make sure that these failures in care are never repeated
- Consider these on your own and as part of team meetings, discuss them with students and support staff and consider what this means for you as you care for your patients and members of the public

# Theme 1: Listening to patients, families & staff



**“If those responsible for the hospital had listened properly to what their own nurses said in 1991, and acted, the Panel is clear that the events described in this Report would not have followed the path they did. This should serve as a challenge to all those in positions of authority...**

**When that challenge did come from the families, the documents reveal a pattern of response that even then did not focus on their concerns or effectively address them”**

Panel report, page 320

# What happened at Gosport



- It's now over 27 years since nurses first raised concerns about prescribing practices
- Relatives complained about the safety of patients and their care
- Families were marginalised by professional staff
- Some nurses attempted to raise concerns, other individuals should have been aware
- Patients consistently let down by those in authority – both individuals and institutions
- Story of missed opportunities and unheeded warnings
- Those in authority did not listen effectively and no one attempted to challenge the behaviours

# Pharmacy today – professionals

- Person centred care is at the heart of pharmacy in all settings, with pharmacy professionals embedded in patient facing activities
- Patient safety should be a priority for everyone – from professionals to regulators and representative bodies
- Patients and their carers can expect pharmacy professionals to be their source of information about medicines and to be their medication safety advocates
- **GPhC Standards** – all pharmacy professionals must provide person centred care
- Understand what is important to the individual and adapt care to meet their needs – making the care of the person their first priority
- Strong focus on multidisciplinary team working and shared decision-making

# Pharmacy today – systems



- Clear framework in place for providers of pharmacy services
- RPS standards for hospital pharmacy services –set out what's expected of a quality service
- Services must be safe and put patient needs first
- Pharmacy expertise to support safe and effective use of medicines
- Optimising and making best use of medicines is key
- Assessment of individual patient needs and validation that needs are met through their medicines
- Pharmacy teams work closely with patients, prescribers and other healthcare professionals



# Theme 2: Speaking up



**“There is no evidence available to the Panel to suggest that either the pharmacists or Portsmouth HealthCare NHS Trust’s Drugs and Therapeutics Committee challenged the practice of prescribing which would have been evident at the time”**

Panel report, page 77

# What happened at Gosport



- Prescribing practices involved the consultants, the clinical assistant, the nurses and the pharmacists
- On-site pharmacy was replaced by the remote service
- Pharmacist visits to the hospital continued twice a week and included checks on ward stocks and examinations of patients' drug charts
- System was primarily aimed at maintaining adequate supplies, but there was also a mechanism for raising concerns
- But, no evidence of pharmacists raising concerns about prescribing practices

# Pharmacy today



- Clear professional standards and responsibilities
- Duty to be candid - with the person concerned and with colleagues and employers
- Pharmacy professionals must speak up when they have concerns or when things go wrong
- Professionals more prepared to challenge poor practice and behaviours
- Leaders to ensure that the right culture exists so staff can speak up
- Increased legal protection for those raising concerns
- Multiple resources and guidance to support those who are speaking up

# Pharmacy today



- Increased emphasis on reflection and learning
- Improved quality of care and pharmacy practice by learning from feedback and when things go wrong
- Professionals required to think about what can be done to prevent the same thing happening again
- New revalidation processes for pharmacy professionals
- Professionals required to reflect on how to improve and show how they provide the safe and effective care patients and the public expect

# Theme 3: Controlled drugs



**“One of the most difficult things to understand about these events is why so many people were prescribed and administered drugs that were not clinically indicated, in quantities sufficient to shorten their lives”**

Panel report, page 318

# What happened at Gosport



- Use of controlled drugs formed central part in failures in care
- The principles of safe and effective use of opioids in both palliative and non-palliative care were clearly set out in international and national guidance
- Reflected in local guidance issued in the Wessex Region of the NHS and adopted by Portsmouth Hospitals NHS Trust, which provided medicines and associated pharmacy services to Gosport
- Practice of prescribing and administering drugs at the hospital conflicted with national and local guidance

# Pharmacy today



- Significant changes to the governance arrangements for the use and management of controlled drugs
- Tighter controls through regulations and guidance post Shipman
- Legal requirements for controlled drugs accountable officers (commonly the Chief Pharmacist or assisted by the Chief Pharmacist)
- CDAO role –regularly auditing of controlled drugs matters
- National controlled drugs local intelligence networks
- Reporting of incidents and external inspection by regulators
- Medication Safety Officer roles – managing incidents and improving reporting and learning

# Theme 4: Use of data



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

**It is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned”**

Panel report, page 69



# What happened at Gosport



- The excessive use of diamorphine and midazolam reached a peak in 1998/99
- Documents record both the quantities of opioids used on the wards and the fact that the patients admitted were not assessed as requiring palliative or end of life care
- Even superficial monitoring of pharmacy data should have sounded alarm bells

# Pharmacy today

- Advances in technology and increased use of electronic records
- Electronic prescribing provides the key to more rapid overview of prescriptions
- Enables prioritisation of pharmacist review activities
- Digitalisation, improved provision of information about medicines and automation of stock supplies could potentially have challenged the care of these patients - making what was happening more visible to a broader group of people
- Increased ability to identify prescribing trends

# Theme 5: Clinical governance and audit



**“Towards the end of the 1990s, the culture of challenge should have been reinforced by the advent of clinical governance, which made clinicians and managers accountable for the quality of clinical care, crucially including patient safety.**

**Again, this was slower to take effect in some places than others, and the disclosed documents show that this was the case in the hospital”**

# What happened at Gosport



- Part of the culture was a legacy of the concept of ‘clinical freedom’ – not to question medical decisions
- Failed to look for systemic problems with opioid prescribing
- No routine and regular review of causes of patient deaths and the impact of opioids
- Failure of executive directors, including the medical director, to respond effectively to concerns about opioid prescribing
- Illustrative of the rudimentary state of clinical governance at the hospital at the time

# Pharmacy today



- Clinical governance has developed nationally and over time
- A clear focus on governance – from inside (Trusts/Health Boards) and outside (systems regulators)
- Medicines governance includes strategic overview of medicines use
- Incident reporting and better ways of recording incidents
- Pharmacy services should be aware of incidents causing harm
- Incidents routinely reviewed and discussed
- Understanding of root causes used to prevent future incidents

# Reflections

## What's changed

- Pharmacy practice has developed significantly
- Strengthened requirements and standards on speaking up and duty of candour
- More oversight and assurance processes around medicines and controlled drugs
- Professionals better placed to challenge prescribing practice, working in multidisciplinary teams
- Increased use of technology and data driven care
- Clinical audit and peer review of prescribing practice
- Changing culture, with earlier sharing of information and intelligence

## What more can we do

- Always put patients at the heart of everything we do
- Don't lose sight of the wider system and look out for gaps
- Don't be complacent about the importance of professionalism and human factors
- Speak up when things go wrong or when you have concerns
- Show leadership whatever your role and work with others to create the right culture
- Share ideas with colleagues, discuss good practice and update action plans
- Be vigilant and work together to ensure that patient safety is paramount

# Key resources (1)

- [Report](#) of the Gosport Independent Panel Report
- Government [response](#) to the Gosport Report
- GPhC [Standards](#) for Pharmacy Professionals and Registered Pharmacies
- GPhC [Guidance](#) on Raising Concerns
- RPS [Professional Standards](#) for hospital pharmacy services
- NHS Improvement [Just Culture Guide](#)
- Multiple [resources](#) on Freedom to Speak Up and the National Guardian's Office
- HIW [advice](#) on Whistleblowing and raising concerns

# Key resources (2)

- RPS Safe and Secure Handling of Medicines [guidance](#)
- NICE [guidelines](#): Controlled drugs
- CQC [guidance](#): Safer Management of Controlled Drugs
- Berwick [Review](#) into Patient Safety
- Lord Carter [Review](#) of Acute Trusts' Operational Productivity
- Accountable Officers Network Scotland [resources](#)
- Accountable Officers for Controlled Drugs HIW [resources](#)