Investigation

Investigation into the mental health care for older people provided by Devon Partnership NHS Trust

June 2010
About the Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people detained under the Mental Health Act.

Whether services are provided by the NHS, local authorities, or private or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.
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1. Introduction

In November 2008, a number of concerns were raised about poor practice on the Harbourne Unit, an 8-10 bed unit at Totnes Hospital for older people with ‘organic’ mental health needs such as dementia. The concerns were:

- The inappropriate use of syringe drivers to control agitation in people with dementia.
- The absence of investigations into physical illness.
- A culture of terminal palliative care.
- The use of restraint and medication without considering a person’s mental capacity.

In response to these concerns, the chief executive of Devon Partnership NHS Trust launched a major incident review on 7 November 2008. This included setting up a safeguarding group and a review, by the medical director, of six patients who had died on the unit between October 2007 and November 2008.

The review by the medical director confirmed the original concerns and concluded that there was a marked failure of medical and nursing care for three of the six people. There were also areas of concern in the care of the other three people.

The trust carried out a further internal audit across older people’s mental health services. This included a review of death rates, the use of care plans and the recording of ‘Do Not Attempt Resuscitation’ (DNAR) status. It highlighted that one of the other units had a higher death rate than one would normally expect, but did not indicate a possible cause for this. The audit also included a review of prescribing practice, but this did not point to any concerns.

It was agreed by the safeguarding group that the primary focus of any immediate review would be on the Harbourne Unit, and that a more detailed audit of the other older people’s mental health units within the trust should be carried out.

The records of four additional patients were reviewed, which produced a second report highlighting additional concerns. This included end of life care, medication, prescribing practice, use of control drugs and general nursing practice. It was recommended that a further broader review should take place as it was unable to find conclusive evidence through a review of file records alone.

Throughout these early stages, the trust was in contact with the local multi-agency safeguarding group consisting representatives from the Devon Police, Devon Primary Care Trust, the South West Strategic Health Authority (SHA) and representatives from Devon County Council and Torbay Care Trust. The police concluded from the evidence presented to them that there were no grounds for criminal proceedings.

As a result of the concerns being raised, the SHA supported the trust by facilitating an independent review of medical records and case notes at the Harbourne Unit. In addition, the SHA held regular serious incident meetings internally from January 2009, to check on progress. It also held regular meetings with the trust, Torbay Care Trust, Devon Primary Care Trust, Devon County Council to seek assurance on the implementation of action plans.

We conclude that the trust reacted honestly and openly to the concerns that were raised. The response in terms of safeguarding, the involvement of local agencies and the SHA, and the local
investigation, which led to the trust seeking the involvement of the Healthcare Commission, was appropriate.

**Healthcare Commission/Care Quality Commission involvement**

The Healthcare Commission was first advised of the emerging concerns on 27 November 2008 by the trust’s chief executive. At this stage, it was satisfied with the process to date and requested further briefings when appropriate. The SHA also advised the Healthcare Commission of the early concerns.

The Healthcare Commission agreed to carry out an investigation due to the seriousness of the original concerns and the need to check whether there were similar grounds for concern at the other older people’s mental health inpatient and community services.

The Care Quality Commission took over the duties of the Healthcare Commission in April 2009.

**Investigation process**

The terms of reference of the enquiry are reproduced in appendix A. Our investigation consisted of the following:

- Requests for information from the trust.
- Announced and unannounced visits to all of the trust’s older people’s mental health units and the trust’s headquarters.
- Inspection of pharmacy arrangements and medicines management.
- Talking to people who use services, relatives, carers and interest groups.
- Talking to partner agencies of the trust.
- Interviews of 172 members of staff.
- A case note review.

**Background of the trust**

Devon Partnership NHS Trust was established in 2001. It serves the whole of Devon with a population of 890,000 people. Devon is the third largest English county and is largely rural, with a low population density. It also contains two independent unitary authorities of Plymouth and Torbay. The trust employs around 2,000 members of staff and has about 100 staff members assigned from Devon County Council and Torbay Unitary Authority. The trust’s HQ is in Exeter.

Working in partnership with health and social care providers, the trust provides mental health services for adults up to age 65, older adults, people who have problems with alcohol and substance misuse, people with a learning disability, people with a severe eating disorder who require a stay in hospital, and people who need forensic or secure mental health services.

A list of the trust’s older people’s mental health services at the time of our investigation is shown in appendix B.

The current chief executive was appointed in April 2005. He had been interim chief executive from November 2004. The chair of the trust has been in post since April 2009. When the chief
executive was appointed, the trust was in financial deficit that, when finally determined, amounted to £12 million. An external review into alleged bullying and harassment was being undertaken. This revealed that there were deficiencies in human resources management, a lack of clinical engagement and a culture of fear. The trust was also the subject of a cross parliamentary debate. There was concern that the trust was not working well with its partners. There was also adverse publicity from incidents involving suicides of patients at the trust.

From a commissioning point of view, the arrangements were unwieldy, since the trust had to deal separately with seven primary care trusts commissioning its services.

The trust embarked on a programme of financial recovery. Financial break even was achieved in 2006/07. The financial strategy consisted of three elements: identifying and reducing waste; identifying areas requiring funding for commissioning; and identifying areas of financial growth. At the same time, a decision was taken to have one lead commissioner representing all of the seven local primary care trusts, including Torbay.

**The role of the trust’s inpatient units**
The trust describes its inpatient services as providing a place for comprehensive assessment and treatment of individuals when it is no longer possible to support them safely in the community.

For those experiencing ‘organic’ disorders, such as dementia, the inpatient units provide assessment and treatment where this cannot be provided in an alternative setting, for example at home or in respite care. The trust also provides: pharmacological and psychosocial treatments; advice, support and education for families, carers and other professionals; close working relationships with community mental health and the wider health and social care community; services under the Mental Health Act; and assessment and support for those who meet the admission criteria for onward placement in residential settings. It describes its inpatient units as offering single-sex accommodation in dormitories or designated single rooms.

**The role of the community mental health teams**
The trust describes its community mental health teams as providing secondary mental health services for people with functional conditions such as bi-polar illness, schizophrenia, depression and mood disorders where the rate or degree of disability has become significant to the individual or others, as well as services to people with organic conditions including dementia.

The function of the community teams is to: provide prompt and expert assessment of mental health problems; provide effective and evidence-based interventions; maximise independence; reduce the frequency of inpatient admissions and length of stay; focus on rehabilitation and recovery; actively involve people who use services and their carers in the planning, delivery and monitoring of services; and agree an action/care plan with the person and their carers.
2. Allegations of poor care at the Harbourne Unit

When the concerns were first raised about the Harbourne Unit, the trust conducted an initial review of the care carried out at the unit. The trust’s medical director undertook a review of patient notes for six people who had died on the unit between October 2007 and November 2008. All of these people were admitted for assessment and management of dementia with accompanying challenging behaviour.

The medical director found that there were several areas of poor medical practice by the consultant and staff grade doctor as well as some nursing staff:

- A lack of timely, appropriate and simple examinations of people’s physical and mental state.
- A record of ward rounds, examination and rationale for treatment decisions was often not made.
- An apparent lack of consideration of the potential contribution to the deterioration of a person’s mental state from medication side-effects and/or polypharmacy.
- A lack of understanding of the importance of monitoring food and fluid intake.
- An unsophisticated understanding of the meaning of palliative care and a lack of a stepped care approach (with the exception of one case where the palliative care team was involved in the patient’s care).
- Do Not Attempt Resuscitation (DNAR) orders were often not completed in a timely way.

The medical director also identified the following poor care at Harbourne:

- A lack of multidisciplinary responsiveness to patients’ distress.
- Often a surprisingly swift move to deliver drugs parentally (that is, injected) without consideration of the underlying causes of the patient’s condition and, on one occasion, the decision to start a syringe driver was made without discussion with senior medical staff.
- There were no nursing care plans for most of the patients reviewed.
- In the case of one patient, repeated intramuscular sedation was given without discussion with medical staff.

The medical director identified unusually frequent use of syringe drivers to administer opioids and benzodiazepines when other alternatives and other routes of administration were possibly still available. He also commented on the high doses used (two to four times the recommended starting doses). He stated that members of staff at Harbourne had used syringe drivers “on many occasions” and would have known that patients would be unlikely to live long when prescribed these drugs at these doses.

They continued to prescribe high doses and there is no record that they, on any occasion, considered decreasing the dose, for example, in order to assess whether a patient’s agitation or pain could be managed so they were less sedated and able to eat and drink. This observation is in the context that people being treated by this unit were often close to the end of their lives.

In the opinion of the trust’s medical director, there was a marked failure of medical and nursing care in three out of the six patients reviewed. There were also areas of concern in the care of the other three patients. There were five patients who received medication by syringe driver. Of
these, one was under the supervision of the palliative care team and had medication prescribed at lower doses. For the other four people, medication – especially midazolam – was prescribed at doses that were higher than normally would be expected.

The director found concerns about the keeping of patient record notes. A record of ward rounds, patient examination and rationale for treatment decisions was often not made. He stated that there appeared from the notes to be a lack of understanding of the importance of monitoring food and fluid intake. Resuscitation decisions were often not completed when they should have been. There were no nursing care plans for most of the patients. There was evidence that standard nursing care was not being documented. Because of the lack of detail in the notes, though patients were deteriorating, it appeared that nobody was picking up on simple issues such as checking blood and fluids or thoroughly examining patients.

We visited Harbourne several times during the course of our enquiry. We cover the ward environment in chapter 5. In summary, the environment there was not suited for elderly organic patients with dementia. The unit was housed on the first floor of a community hospital in Totnes. We found the layout of the ward confusing and observed that dementia patients found it confusing too. The ward, although in a modern building, had windows that did not let in much natural light. Its location on the first floor made access to any outside space difficult. It was situated on a busy road near to a busy roundabout and opposite an ambulance station with sirens sounding at different times of the day. In contrast to the other units, we found the décor stark and minimal.

There was a lack of a stepped care approach to pain relief. There was a tendency to progress to the use of opioid patches in patients before trying other approaches. There was also a general lack of challenge from nursing staff towards the practices favoured by the consultant. When members of Harbourne staff were asked if they thought there was any other way of managing severe behavioural and psychiatric symptoms in dementia, the general response was that the decision making was down to the consultant and the junior doctor at the unit.

The situation at Harbourne is in the context that, in recent times, the unit was caring for patients that were more severely and acutely ill than previously. There was a tendency also at Harbourne for the unit to deal with end of life care when other units would have transferred such patients elsewhere. The question mark remains, however, in terms of whether enough consideration and alternative methods of treatment were sufficiently considered before embarking on a regime that was, in fact, end of life care and whether this was clinically appropriate in every patient’s case.

Following the raising of the concerns, the staff at the Harbourne unit were subject to extensive scrutiny. In the year before, the ward manager had been largely absent due to personal circumstances. As a result, the ward was run by the deputy ward manager. From interviews and observations, members of staff stated that they were doing the best they could for their patients at the time, with weakened management support within the unit and little support from elsewhere in the trust.

After one unannounced visit to the unit in July 2009, we raised concerns about the conditions under which a level 4 constant observation patient with dementia was being accommodated on the ward. He was at that time being kept largely isolated from the other patients on the ward in a four-bedded room on his own, which had had all furniture removed apart from a single mattress on the floor and an armchair for his nurse observer. We also raised concerns about the cleaning up of urine and clearing of the patient bathroom of clothing and towels. By this time,
there were very few patients on the ward and the trust was having particular difficulty in obtaining sufficient staff to cover the ward.

The trust responded promptly to our concerns. In her response to us, the executive nurse confirmed that the case of the patient on constant observation was the subject of ongoing review at a multi-agency performance management group and that a review of the patient’s notes provided evidence of assessment of mental capacity, best interest decision making and the regular review of the patient’s care plan (with involvement of the patient’s relatives) and medication. A slippage in the standard of hygiene was acknowledged.

The trust had already been considering the future of the unit, and, soon after, took the decision to suspend the service at Harbourne on the grounds that an adequate standard of care could no longer be guaranteed. The remaining patients have been relocated to other accommodation.
3. Standard of care at other units of the trust

Findings

- We did not find the same level or concentration of concern about practices at the trust’s other mental health units for older people.
- However we did find individual issues of concern.

One of the early tasks of the enquiry team was to look at the general standard of care at the trust’s other mental health units for older people, and to check if there were similar concerns to those that had been expressed about Harbourne.

First, we conducted an early inspection of all the units to alert us and the trust to any immediate problems. Second, we commissioned a review of patient notes at all the units to give us a more in-depth picture of the care provided and to determine trends, good practice and areas where practice could be extended or improved. Third, we carried out a longer programme of visits to each unit as the enquiry progressed. This included a number of unannounced visits, which took place both during the day and in the evening.

The inspections were undertaken by Mental Health Act commissioners and a member of CQC’s mental health team. Apart from one visit in May, they took place in June 2009.

When we came across any issues that we felt needed the trust’s immediate attention, we wrote to the chief executive with details of the concern and requiring a response by a given deadline. The trust responded promptly to these.

Summary of findings from initial inspections

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<th>Training, qualifications and clinical supervision</th>
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<td>There was a lack of regular staff appraisal and clinical supervision of members of ward staff.</td>
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Members of staff received training in the Mental Capacity Act as part of a training project in July 2007 and an e-learning module in April 2009, but little on how to put it into practice and monitor performance. The trust accepted that its knowledge and use was not fully embedded.

The levels of qualified staff per shift were frequently low, with only one qualified nurse per shift in some units.

Training in anything other than mandatory training was poor, although some units have taken it upon themselves to arrange local training. Mandatory training was limited to e-learning, which did not provide detailed learning beyond basic principles. Lack of appraisals meant that training was not formally linked to staff development.
Changes to the Mental Health Act 1983, which was amended by the Mental Health Act 2007, had not been properly implemented. The inspectors found scant knowledge of the role of the Independent Mental Health Advocate (IMHA) or changes in relation to electro convulsive therapy (ECT) introduced by the 2007 amendment.

There was no standard model for consultant, foundation, middle grade and junior doctor cover on the older people’s mental health units. Some units made use of general practitioners and others did not.

The presence of occupational therapists and ward clerks was variable, and access to other support such as physiotherapy, dietician and social worker was variable to low.

**Medication and pharmacy**

At the time of inspection, drug cupboards were overcrowded with stock on some units.

At the time of the inspection, medicines charts varied from unit to unit and seemed to be those of the neighbouring acute trust providing pharmacy services.

The use and attitude to the use of syringe drivers varied. Members of staff at some units did not have experience of using a syringe driver, whereas on others it was in infrequent use. The administration of syringe drivers was undertaken by hospice staff, with monitoring by unit staff. Where this practice was being used, training was received from hospice staff.

At the time of the inspection, the trust did not have a policy on the use of syringe drivers.

The procedures for the use of syringe drivers by specialist non-DPT staff are now contained in the trust’s End of Life Policy C37, which was ratified in August 2009.

Access to pharmacy advice and support was variable, depending on the location of the unit in relation to the pharmacy unit provided by neighbouring trusts.

**Environment**

Ward environments were generally good. All units visited were clean and well kept. Most had outside patio and garden areas. Members of staff tried to maintain single-sex accommodation, but the limitations of the wards did not guarantee this level of dignity. The number of toilet and bathroom facilities varied. The trust stated that it intends to address the issue of single-sex accommodation in future development plans.

Two adjacent wards (Rougemont and Westleigh) shared one sluice room, with staff having to pass through one ward to get to the sluice room. This was an infection control risk and we reported it to CQC’s infection control team. The trust stated that separate sluice facilities are part of the refurbishment programme for these units.

Since the trust was formed in 2001, individual units appear to have developed their own styles according to local resources, personnel and environment. There was little tangible evidence of a uniform service strategy or service delivery.
We noted as our visits progressed that the trust was beginning to address some of the issues. By the time we had visited the last unit, we had begun to see early indications of improvement in areas such as training, staff appraisal and supervision, and ward environments (including better drug storage facilities).

**Summary of case note reviews**

The second strand of our review of the other units was to carry out a review of patient notes. This was done by external consultant old-age psychiatrists in conjunction with a consultant psychiatric nurse.

We did the review in two stages and were able to feed back our initial findings to the trust so that they could begin a programme of improvement.

We found evidence of good care at some units, with appropriate admissions, prompt DNAR (‘do not attempt resuscitation’ status) assessments, multi-disciplinary planning and care plans, frequent involvement of people who use services and family members in key treatment decisions, access to therapeutic activities, and people’s records and drug charts being kept and stored appropriately.

At other units, the care was judged as good, containing many of the same elements, but not quite to the consistent standard of the best units.

The care of people at St John’s Court and Harbourne presented significant concerns due to the lack of comprehensive care planning and physical monitoring.

The use of opioids with inadequate multi-disciplinary team assessment and planning was confined to Harbourne.

**Findings by specific area of care**

**Documentation**

- In the past, the trust had not given sufficient attention to the standard of patient documentation.
- The nature of patient notes appeared very different at different units, reflecting the relative isolation in which they all appeared to operate. There was a lack of uniformity in style.
- Audits of patient notes were not taking place although, as the enquiry progressed, we became aware that audits were starting to be undertaken by the trust.
- In many instances, the rationale for decisions about care were not being documented in notes and, in some instances, evidence of basic nursing such as weight, fluid and nutrition measurement were not being recorded.
- In other instances where there was recording, there was no documentary evidence about rectifying measures being taken. In the majority of cases, resuscitation decisions were being documented, as were 72-hour risk assessments.
Planning of care

- One of the major issues we found was that there were no formalised care plans throughout the trust. Units had either developed their own or were using standardised care plans obtained from elsewhere.
- In certain instances we found the use of patient care templates, which had been inserted into patient records without being personalised to the individual patient.
- The trust is now rolling out a programme of introducing the RiO patient note system at all of its units, which will help to standardise patient care note taking and recording. Clinicians will have to enter data, which will mean a more transparent set of information about individual patient care and indicate patient care problems if they arise. The trust stated that the RiO system should be in place by May 2010, with full coverage in the trust by December 2010 with the exception of Learning and Disability Services.

Lack of uniform drug charts

- Allied to the lack of a standardised approach in relation to patient records, we noted that there were five different drug charts in use at the trust, which had either been inherited from previous organisations or were linked to different pharmacy supply systems.

The case note reviewers were able to identify the following improvements in the later case notes that they reviewed, from a total of 38 case notes.

- There was evidence of improved care planning: the reviewers saw a greater number of care plans in the case notes and they were more relevant to actual care of the individual patient.
- There was evidence of occasional care plan reviews, though this number needed to increase.
- There was evidence of recording of some involvement of multidisciplinary working.

Areas for improvement identified from the case note review

At the end of the case note reviews, we were able to summarise that there remained significant areas for development as follows:

Care planning

- Care plans were often in template form, whereas they should have been modified/individualised/annotated according to patient need.
- Care plans should be reviewed regularly. The reviewers found that most care plans had been subject to a ‘one off’ review only.
- Care plans should reflect all the important needs of the patient, for example pressure care/nutrition. There were still too many examples seen of rating scales where risks were identified without an associated relevant care plan being present.

Physical health care

- The MUST (Malnutrition Universal Screening Tool) nutrition assessment tool was present in some notes, but weight was not regularly checked in most patient notes reviewed.
- Some patients did not have a height or BMI (body mass index) recorded.
• Underweight patients did not usually have a care plan for nutrition or dietary supplements, or advice from dietician recorded.

• Several patients were noted to have diabetes, but they did not have a clear care plan for frequency of blood sugar monitoring or weight management.

• Very few patients had a blood pressure, pulse, temperature chart, even when on medication or when physical disease indicated the need for monitoring.

• Patients noted to have swallowing problems did not routinely have a formal swallowing assessment that, if completed, could have indicated a need for thickened fluids.

**Multidisciplinary working**
The National Service Framework (NSF) for Older People (7.47 and 7.48) advises that core members of a specialist mental health service community should include:

- Consultant psychiatrists specialising in mental health problems in old age
- Community mental health nurses
- Clinical psychologists
- Occupational therapists
- Social workers.

They should include agreed working and referral arrangements with:

- Speech and language therapists
- Physiotherapists
- Dieticians
- Chiropodists
- Community dental services
- Pharmacists
- District nurses.

From the case note review, occupational therapists were occasionally evident in patient notes, but it did not appear that all ward teams have access to occupational therapy skills and interventions. Access to dietetics, physiotherapy, pharmacy, psychology, and speech and language therapy seemed very sparse.

**Ward rounds**
Many ward round notes were brief. It was not always clear that the medical review had considered suitable interventions for all the psychiatric, physical, psychological and social issues that were contributing to the problem.

**Harbourne and St John’s Court**
Despite noting a general improvement, albeit still with some areas of development to address in most of the units, later review of notes at St John’s Court and Harbourne still reflected the initial concerns, raised at the beginning of the case note review, into comprehensive care planning and physical monitoring of patients.

For example, a patient at Harbourne was found to have been inappropriately prescribed an opioid patch and medication via a syringe driver for distress and challenging behaviour. A patient’s care at St John’s Court was also of concern, in that unclear documentation failed to fully support the decisions made with regard to medication and the use of a syringe driver.
Evidence of palliative care in the case notes

It is important that, where necessary, a palliative care specialist is contacted who can review the patient and provide regular advice in relation to palliative care management (including the use of opioids). The psychiatrist, other medical staff and nursing staff on the ward should share skills and knowledge with local palliative care specialists, to provide quality palliative care to these patients. This includes early involvement of the patient’s family and/or carer to ensure they are part of the planning and delivery of palliative care.

In relation to palliative care of patients with dementia, the case note inspectors found little evidence of tools being available to consultants for those patients who were assessed as being in pain before the initiation of fentanyl (strong opioid) patches.

It is difficult to communicate with these patients to ask if they felt any pain. The case note reviewers did not identify any pain assessment tools within the case notes reviewed for patients who were unable to communicate.

There was evidence of advice being sought from a Macmillan nurse over the telephone, but no evidence in the patient notes that a Macmillan nurse had seen the patient. At two units there did not appear to be evidence that a palliative care specialist had been asked to review patients with dementia who had deteriorated.

We found from the case notes that there was confusion on some units about the concept of palliative care (which is aimed at the relief of symptoms rather than the treatment of a disease or illness when a patient is close to death). Palliative care approaches were used for some patients who were not close to death but who had challenging behaviour that was difficult to manage.
4. Adequacy of the trust’s model of mental health care for older people

We carried out a review of the trust’s model of mental health care provision for older people. We used evidence provided by the trust plus our own analysis of that evidence, interviews with trust staff and our own observations.

Findings

- The trust lacked a clear vision and understanding of the actual services that the older people’s mental health units were operating. There appeared to be a variety of care philosophies in operation.
- Implementation of the relevant recommendations of the Sainsbury Centre Report was inconsistent.
- The trust lacked a consistent service model for its older people’s mental health units.
- There was no consistent model of medical cover.
- Clearly defined patient pathways were not evident at every unit.
- The trust did not have standard patient admission and assessment practices across its older people’s mental health units.
- At the time of the incident at Harbourne, there was no crisis resolution team for older people’s mental health.
- At the time of the incident, we found no trust policy in the management of challenging behaviour in patients.
- At the time of the incident, we found no trust policy in palliative and end of life care.
- Out-of-hours cover was variable.

The Sainsbury Centre report

In 2004, the Sainsbury Centre for Mental Health was jointly commissioned by the trust, Devon County Council and the seven local primary care trusts to conduct a review of the older people’s mental health services in Devon. The final report, “Devon Older People’s Strategic Partnership: Future Development of Mental Health Services for Older People” was published in April 2005.

The report aimed to produce a clear strategy for older people’s services. It suggested moving to a new model of care, with more focus on enhanced community services and a reduction in inpatient services.

The key proposals and recommendations were:
- Primary health care (GPs) and social care to be the initial access point for assessment and support.
- Development of fully integrated specialist community mental health teams for older people.
- Access to dedicated organic and functional mental health beds.
- Rationalisation of inpatient units to support dedicated provision.
- Review of inpatient bed numbers in the light of development of greater community services.
- Development of specialist home support services.
• Setting up of crisis resolution teams and home treatment, including assessment of need in relation to access to adult mental health services.
• Development of community services to support patient recovery and social inclusion.
• An information and communications strategy to support service user and carer empowerment.
• Development of, and sustained support to, an older people’s mental health user and carer network.
• Leadership across all partner organisations at PCT level and across PCTs in Devon.
• Commissioning expertise and capacity at PCT level and across PCTs.

We assessed how far the above recommendations had been implemented throughout Devon.

The seven PCTs, Devon County Council and the trust established a Devon Implementation Group, chaired by the chief executive of the North Devon PCT.

We noted that implementation groups included trust staff. The members of staff we spoke to said that they had personally invested a lot of time and effort in an attempt to see the recommendations implemented. However, our conclusion is that the implementation of the recommendations of the report was geographically patchy. In some areas, the PCTs, County Council and the trust went further down the line in implementing the changes than others.

There appear to have been a number of reasons for this. Implementation, while treated initially with enthusiasm and linked to a joint implementation strategy, involved seven separate PCTs.

There were local differences in how the recommendations should be implemented. Later in 2006, during the national reconfiguration of PCTs when the seven were condensed into two, some impetus was lost and this reconfiguration seemed to overtake progress.

In Torbay and South Devon, the situation was different. Following the Sainsbury Centre review, a multi-agency group focused on development and implementation. A 19-bed rehabilitation unit was closed and resource was reinvested in the community. The implementation group also highlighted that older people’s mental health services were not integrated and took steps to remedy this. There was more success in implementing the recommendations and this was undoubtedly aided by the unitary authority status of the area and a close working relationship between health and social care.

We conclude that, given the detailed recommendations of the Sainsbury Centre report and the initial enthusiasm of members of trust staff to implement it, the patchiness of the final implementation was a lost opportunity.

**Service model**

We found a lack of a consistent model across the trust. We also noted that many units were delivering a dual function of caring for both functional and organic older people with mental health difficulties. Mixing patients who have depression with those who may be confused or agitated is not good practice.

There was no uniform provision of medicines management, psychology services, occupational therapy provision or speech and language therapy or access to dietary services.
One reason for the differences stemmed from seven PCTs with different commissioning arrangements for their patients. Even when the lead commissioner was reduced to one PCT, we did not find any increase in consistency of model of care or a clear set of quality assurance standards. The older people’s mental health units had developed independently of each other. Although the target length of stay at all units was set at an average 35 days, a study of actual length of stay showed variations from an average of 38 days to an average of 65 days.

Due to different commissioning arrangements, the resources invested in different parts of the trust were not allocated on a fair and equitable basis. The trust recognises that services for older people have not kept pace with those for younger adults and require modernisation to ensure that older adults receive a commensurate level of service.

**Medical cover**

We found differences in medical support, which depended on a combination of historical arrangements and the ease or difficulty of obtaining suitably qualified consultants and other medical staff. While all units were covered by a consultant, this varied from having a dedicated substantive consultant at most units to, in one case, a series of locum consultants for a period of about five years.

The provision of junior doctor medical support to the consultant also varied. Two units had GP-only support, one unit had junior doctor and GP support, and a further unit had just junior doctor support. At one unit, the junior doctor cover was deemed unsatisfactory and the ward manager preferred to do without. We observed different levels of satisfaction with overall medical cover. There were mixed views over whether support was better provided by a GP or a junior doctor. We conclude from these different arrangements that the trust has not examined or designed a standard model of medical cover.

**Admission**

In terms of criteria for admission of patients to its older people’s mental health units, there was no overall trust policy and therefore the criteria for admission seemed variable unit by unit.

At some units, there appeared to be little rationale employed when determining whether to admit patients and there appeared to be a lack of assessment from the outset. Opinions were expressed by other members of staff that more than one unit was being used as a “bail out” unit for the local district general hospital and the general health economy, rather than functioning as an acute assessment unit.

We found no evidence of a trust-wide admission protocol and during the course of our enquiry we ascertained that the trust were about to trial a new admissions protocol at one of its existing units. Some staff complained that admission to inpatient units was necessary due to inadequate community mental health resources and this had led, in some places, to a culture of admitting people to inpatient units rather than trying other solutions.

There is no crisis resolution team for older people’s mental health. This means that some patients are admitted to inpatient units when they could have been treated more appropriately in the community. Since the investigation began, the trust has stated that it has approved plans
and resources to recruit additional staff to work in the crisis resolution service, so that it can expand its remit to include older adults.

Assessment

In our visits to the older people’s mental health units, we did not find clear evidence of standard two-hour and 72-hour assessments in all units for all patients. The trust is beginning to recognise that it needs to have uniformly agreed eligibility criteria and this requires uniform assessment practices across the units. This requirement is becoming critical, as the movement to community-based services is leading to individuals with higher dependencies being admitted.

In some areas of the trust, there was more recognition of a community public health point of view, where the role of the inpatient unit is to stabilise patients and then discharge them to an appropriate setting, for example a psychiatric nursing home, or return to the community. Without clear assessment criteria, the effect is that patients may be occupying beds inappropriately and are “bed blocking” patients that are more severely ill. We also found that the local health economy was affecting this area, and in one location a unit was taking in patients due to lack of close facilities nearby.

Care pathways

A care pathway (otherwise known as a critical pathway, integrated care pathway or care map) is a tool to standardise care processes and to maintain the quality of patient care in a patient group. The use of a standard care pathway reduces variability in clinical practice and promotes organised and efficient patient care that is based on evidence.

We saw evidence of dedicated nursing staff, but in many cases we could not readily identify a defined care pathway from our observations, review of patient records and interviewing of individual members of staff. We did not find clearly defined processes and standards of referral and admission and patient assessment. It was also difficult to see identification of mental capacity, clear planning of care and treatment, the identification of interventions, review and evaluation of any treatment, and clear evidence of discharge planning.

The management of challenging behaviour in dementia

We would have expected to see a trust policy document that gave a description or definition of challenging behaviour in the context of older people with mental ill-health. This would also contain service issues that would be tailored to such challenging behaviour. It should include any multi-agency or multi-disciplinary involvement as well as treatment options, taking into account the safety of patients and members of staff and carers, and including risk assessment. It should also specify the environment in which such treatment should occur.

We observed adequate measures in place at a local level, with staff knowing clearly what to do in terms of observation of patients at different levels, either at intervals or in constant observation, where a patient is in danger of self harm or in danger of harming others.

Less clear were some of the arrangements we saw at one or two units where soft mattresses were used in individual rooms to prevent a patient hurting themselves through falls. In one such...
room, we noted potential ligature points and we immediately brought these to the attention of the trust.

At another unit, we found a patient on constant observation but we were disquieted at the starkness of the accommodation for this highly disturbed patient. It was a former four-bedded ward that had been cleared of all furniture, apart from a mattress and an armchair for his nurse observer. In raising these concerns, we found that the trust had no written policy or training in the quality of care standards and practices in the case of such challenging behaviour.

Earlier in the enquiry, in our interviews with carers, we came across one case of a patient who had lashed out at nursing staff. The response of the ward consultant had been to transfer the patient to a more secure unit, to the obvious distress of both the patient and his relatives. We are not able to comment on the individual case in terms of whether the transfer of the patient was appropriate, but we can say that such decisions need to be taken within the framework of the trust having a policy for dealing with challenging behaviour, so that it would be able justify such a decision in the light of all possible interventions.

We recognise that this is a difficult area of care. This is what prompts us to state that it is necessary for the trust to have such a policy, to show that it has thought through all the potential causes and possible solutions when presented with incidents of challenging behaviour.

**Palliative and end of life care**

The World Health Organization defines palliative care as “the active total care of patients whose disease is not responsive to curative treatment”.

End of life care is an important part of palliative care. It usually refers to the care of a person during the last part of their life, from the point at which it has become clear that they are in a progressive state of decline.

We found a mixed picture when we asked staff to describe their practice and trust guidance in relation to palliative and end of life care, and we found different approaches across the trust.

At one end of the scale, at Harbourne, we found that people stayed on the unit longer and it was appropriate to deliver palliative care and end of life care. At the other end, the attitude of other units was to try to stabilise patients and discharge them to an appropriate setting. In between, we found that some units might treat one or two patients a year at the end of their life by following the Liverpool Care Pathway. In other units, we found clear local practice and good liaison with Macmillan nurses to deliver palliative and end of life care.

**The Liverpool Care Pathway**
The Liverpool Care Pathway was developed to improve the care of patients in their dying hours and ensure that they were not being “overmedicalised”. It is described as a “template” to health workers to guide the care of the dying.

The goals of the pathway prompt staff to consider the continued need for invasive procedures and whether current medications really are conferring a benefit to the patient. The pathway also recommends that the situation should be discussed with relatives and if possible with the patient themselves. The guidance recommends that a patient’s condition is regularly assessed.
What was abundantly clear was that, notwithstanding any trust protocols, there was no clear uniform strategy or approach across the trust to palliative care and end of life care. The trust needs urgently to determine not only its policies and strategies in respect of this, but also to ensure that common practices are put in place across the trust. This means bringing together all its old-age consultants across the trust to establish a commonly agreed process.

At Harbourne, people were treated in a palliative care approach when the unit should have been giving greater consideration to treating the root causes of behaviour such as physical illness, depression, psychosis, adverse environmental conditions, fear and disorientation.

We asked one consultant about her experience of end of life care. This consultant described limited experience of end of life care. She said that she has a community public health point of view, in that they try to stabilise patients and discharge them to an appropriate setting.

Macmillan nurses were used for palliative care when it was required and there was appropriate use of the Liverpool Care Pathway for end of life care. However, we did not find that the Liverpool Care pathway was used in all cases. The trust lacked clear protocols that were readily understood by the staff as to what care they should be looking to deliver in terms of end of life care.

Lack of certainty was expressed by some staff in terms of the kind of care they were expected to deliver. Some were unsure if the trust wanted to treat inpatients as if they were in a nursing home. This lack of certainty left some staff feeling unsupported by the trust. There is a risk of trying to alleviate the pain of some patients rather than sending them to hospital.

The trust had produced a new end of life policy, which was implemented in July 2009 and which incorporates guidance for mental health practitioners on palliative and end of life care. However, we were unsure how many staff had been trained on this.

**Out-of-hours cover**

We found concerns with out-of-hours cover at some units. At Abbotsvale, probably one of the most isolated of the trust’s mental health units for older people, we were told that there was no medical cover out-of-hours between 5pm, when the day staff went home, and 6pm when Devon Doctors Out of Hours service becomes available. There were only two staff, including one trained nurse, on duty at night and, with difficult patients, there were occasions when nursing staff said they felt unsafe and at risk. The trust has since asserted that this period is covered by an on-call consultant psychiatrist. However, this did not appear to be known at the unit when we visited.

**Discharge of patients**

We became aware that the local care economy has an impact not only on what units can deliver in the form of services, but also on how quickly patients can be discharged into the community or to a residential care facility. Although the target length of stay at all of its mental health units for older people was set by the trust as an average of 35 days, a study of the actual length of stay showed variations from an average of 38 days to an average of 65 days.
Several trust managers told us that, in 2008, Devon County Council Social Services and Devon PCT decided to reconfigure community services for older people and to establish complex care teams. However, Devon County Council asserts that it worked in partnership with Devon PCT and the trust in 2007 to develop and implement these teams for people with complex care needs.

Despite an additional eight social workers being employed (according to Devon County Council), these became part of general adult social care teams. Members of trust staff told us that, where previously there had been dedicated approved social workers experienced in older people’s mental health issues often working alongside, and in the same locations, as community mental health workers and the inpatient units themselves, these were now either withdrawn to other locations or had longer communication lines between them and the community mental health teams.

The result, though probably not intended or envisaged, was that in many cases the previous close working relationships and cooperation in issues such as patient discharge were deconstructed, leading to delays for example in arranging discharge of inpatients either back into the community or to another care facility.

Since the complex care teams have been put in place, some work has been done locally to improve ways of working. However, we were told that there were still ongoing problems in Exeter and East Devon. On the ground, the realignment of social care staff means that they appear to have less time to spend on referrals and, in some locations, there is now a lengthy waiting list for patients to see the complex care team.
5. Environment and facilities

Findings

- In most cases, the environments of the older people’s mental health units were pleasant, clean and with access to open areas.
- The trust was unable to guarantee single-sex accommodation, although staff did their best to ensure it within the limitations of the units’ environments.
- Pressures on accommodation meant that, in some instances, organic and functional mental health patients, each with different needs, were cared for on the same unit and this is not ideal.
- Toilet and bathroom facilities were insufficient to guarantee full patient dignity in all cases.
- The environment at Harbourne was unsuitable for older people living with dementia.
- The environment at the David Barlow unit was poor.
- At the time of our enquiry, the trust did not have a policy and standard practice on the use of “soft rooms” for patients at risk of self harm.

The NICE and Social Care Institute for Excellence, ‘Dementia: Guideline on Supporting People with Dementia and their Carers in Health and Social Care’ (2007) says that “health and social care managers should ensure that built environments are enabling and aid orientation” of patients. It goes on to say that “when organising and/or purchasing living arrangements or care home placements for people with dementia, health and social care managers should ensure that the design of built environments meets the needs of people with dementia and complies with the Disability Discrimination Acts 1995 and 2005, because dementia is defined as a disability within the meaning of the Acts”.

It further states that “health and social care managers should ensure that built environments are enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and access to and safety of the external environment”.

There was no consistency in terms of environment between the trust’s older people’s mental health units. Their relative isolation seems to have led to variations in the facilities available. On our visits, we found that some units had a pleasant environment whereas the environment in others was less good. We found ward managers and nursing staff generally trying to make the best of the environment available to them.

Privacy and dignity were compromised by a lack of single-sex accommodation. Most of the units had dormitories. There was a general lack of single rooms. We found that ward staff did try very hard to keep the sexes segregated, but this was often by an imaginary line that sometimes had to be moved to accommodate different numbers of men and women. We noted that it was not always possible to segregate the sexes in practice and the trust needs to address this in its redesign of facilities. We were told of instances where female patients had been scared when male patients had wandered into their bedrooms at night.

Overall, we found insufficient toilet facilities for patients, with sometimes only one male and one female toilet. There were separate toilet facilities for staff in most of the units. Where these were located in non-secure areas, we could perhaps accept this more readily. But we found it
difficult to see justification for separate facilities on the wards, since this hampered patient choice.

Many of the units were designed and built about 20 years ago. In some units, there appeared to be a lack of storage space.

Because of the nature of their condition, many patients living with dementia need space in which to wander around or be alone with their families. This was more possible in some units than others and, when units were full, this would create pressure on space needed. The lack of space impacts on patients, who often get more frustrated, anxious and restless as a result. One member of staff told us that they had heard patients say that they felt caged-in or imprisoned. Another member of staff told us that they struggled to give sufficient attention to people with functional mental ill-health because of the extra time needed to devote to people with organic mental ill-health, such as those with dementia.

In one location, there were two units side by side. Only one unit had sluice arrangements, which had to serve both wards. This meant that bedpans from the adjacent ward had to be carried through the next door ward. This was far from ideal when navigating past patients whose behaviour might be confused and unpredictable. We felt that this was not only an environmental, safety and dignity issue but equally a potential infection control issue.

Below is a summary of individual conditions we found at the older people’s mental health units that were open during the length of our enquiry.

Harbourne

The Harbourne unit was unsuitable for purpose. It was noisy with a confusing layout, unsuitable for people with dementia. It was on the first floor with no ready outside access for patients.

Members of staff we spoke to said that Harbourne was a difficult environment in which to care for older people with dementia. The windows limited natural light. It did not have easy access to an outside garden area without patients being accompanied. The layout of the ward was disorientating, a fact we experienced on our visits to the ward. This contrasted with the other older people’s units operated by the trust, which were relatively easy to navigate. We were told that, originally, the nearby Brunel Lodge was meant to be the unit for dementia patients, but that at some point the decision had been made to house dementia patients at Harbourne.

We wrote to the trust following a visit to the Harbourne unit in late June 2009, because we were concerned about a female patient who was seen to be wandering around the ward apparently unobserved by members of staff, and about the conditions under which a male patient who was under a constant level of supervision was being accommodated. We also raised issues in relation to urine apparently being left spilled on the floor of the ward and the state of one of the bathrooms in relation to clothing and towels being left lying about.

Shortly afterwards, in July 2009, the trust announced the suspension of the service at Harbourne on the grounds that it could not guarantee a satisfactory level of service to patients there.
David Barlow

At the David Barlow unit in Barnstaple, we noted the positive attributes of simple layout. The building was designed in a square, with a pleasant inner garden courtyard and access to another external garden area outside the square.

Following an unannounced visit, we wrote to the trust with some overall concerns about the environment and cleanliness of the unit. There were areas that did not appear to have been dusted, with hanging spider trails. We detected a faint smell of urine indicating that, while it had been cleaned up, it had not been neutralised. We were told that this was due to the pipes on the ward.

Despite a promising aspect of two garden areas, these were generally unkempt with weeds growing between the paving slabs. We also came across a pile of condemned mattresses, which had been left in the inner courtyard area. We were told that the unit took in a more difficult client group and again there was a regrettable mix of organic and functional patients. There were damage marks to the plaster on the walls in some locations, indicating a lack of basic maintenance and adding to the slightly shabby feel to the ward.

The unit had only one shower and one bath – the latter at the time of our unannounced visit was not working. The bath could only be used by patients who were hoisted and was far from ideal.

The sluice room appeared too small and members of staff told us that they would often have to leave some commodes outside when cleaning them due to the lack of space.

Lack of space also meant that dirty linen and clothing waiting for laundry was stored in one of the bathrooms. We also noted hoist equipment kept in a corridor because it could not be stored elsewhere.

The trust responded to our concerns and told us that these issues would be rectified. We will make this the subject of a follow-up visit in due course.

Brunel Lodge

This is in a pleasant location one mile from the centre of Newton Abbott. There was easy access to an outside garden area that appeared to be in regular use. We noted at the time of our visit that at least one patient was being actively encouraged to undertake some gardening activity.

The environment was clean and we found a strong supportive team spirit among the staff from ward manager, nurses, nursing assistants and housekeeping staff. We also detected a good working relationship between the consultant and nursing staff. This unit was originally a functional unit but, following the closure of Fernworthy ward and the raising of concerns at Harbourne, had become a mixed functional and organic unit, which was causing problems due to the amount of time being devoted to the organic patients.

We had some concerns that a “soft room” was being used without this having been properly assessed for risk. The trust does not have a policy on soft rooms. The trust’s description of the term to us was a room where soft mattresses could be used to cover hard surfaces to prevent a patient injuring themselves through falling or other movement. This room was located at the
end of the ward and had a low bed. We were told that the sink could be isolated from the patient using padded mattresses and the room could be used for somebody who has a tendency to bang their head. Staff would also lay padded mattress-type cushions on the floor to protect a patient from falling out of bed and hurting themselves.

We do not question the need for staff to take necessary action to protect patients from injuries resulting from falling. However, when we asked if there was a stated policy or strategy as to when such measures might be taken and the risks involved, we were told there were none in place.

We also noted a number of ligature points in this room, which we immediately raised with the trust’s chief executive, along with the need for a trust policy, as an issue of concern requiring immediate action.

St John’s Court

This unit is also located in a quiet and pleasant location. It houses people with organic illness. We found that the environment was clean. We noted issues of privacy and dignity in relation to lack of single rooms and the inability to guarantee full male and female patient segregation. Members of staff told us that, while the environment was pleasant for patients and relatives, there were not enough toilet facilities for all the patients on the unit and the situation had been made worse when a toilet had been removed from one of the bathrooms. There is access to a pleasant garden area, which helps some of the restless patients.

Westleigh and Rougemont wards

These two units are next to each other. This allows for a clear functional and organic patient split. There is access to a secure garden. The environment was clean and pleasant for patients. We noted that there was a lack of storage space. Some equipment is stored on the wards or in four garden sheds. There is only one sluice, shared between both wards. There were problems with privacy and dignity in that neither ward could guarantee full male/female segregation.

There were problems with lack of space needed to allow patients to wander around or be alone with their families.

Abbotsvale

This unit located in Bideford is the most isolated from the trust headquarters, although it is located on a community hospital site. We found it to be in good condition and clean. At the time of our visit we noted it had a resuscitation kit but no defibrillator. There was good access to a garden area although the fencing surrounding it was not secure. Because of its location and catchment area it houses both organic and functional patients. This unit has had to rely on locum consultants for the last five years and there is only informal junior doctor cover. The unit relies on a doctor from Barnstaple calling in to check patients in the evening. We found this unsatisfactory; although we acknowledge that the trust has tried and so far failed to find a solution. As part of the trust’s necessary review and standard setting needed for its medical staffing levels at all the units this particular resource problem needs to be urgently remedied.
We noted at this unit that it had never had any formal clinical pharmacy input and we were told this had been the situation since the unit opened in the 1980s. We raised this as a cause for serious concern with the trust and we told that in line with the trust’s medicines management development plans this situation would be rectified immediately.

Staff at Abbotsvale told us that they try hard not to have patients sharing rooms that have a functional and organic mix but that it was hard to maintain dignity of patients when it was impossible to have male/female segregation. The unit has formed its own environmental team that looks at furniture, decorations, fittings and hoists and has resulted in a new hoist being introduced.

**Melrose**

The Melrose unit at Tiverton is situated on a community hospital site and has good access to GP support. It has access to a garden. There has recently been an incident where a patient managed to leave the garden and was found wandering. Issues in relation to door and fence security though reported have been slow to be resolved. Again due to its isolation and catchment area the unit houses both organic and functional patients but the unit has single-sex rooms with en-suite accommodation. This unit was recently relocated and there were concerns from members of staff that the new layout of the ward is more confusing for some patients due to the additional corridors. In addition, members of staff told us that some patients become disturbed by the noise of crying babies in the adjacent maternity unit.

**Plymouth**

Devon Partnership NHS Trust has a service level agreement with Plymouth Teaching PCT that provides ward facilities and nursing staff working alongside a consultant who is employed by Devon Partnership NHS Trust for six patients. The allocation is for three older people’s beds on an organic ward and another three on a separate functional ward.

This arrangement appeared to be working well and we had no concerns when we visited this unit on an unannounced visit.

**Other units we did not visit**

**The Bungalow, Honiton**

This was suspended during the time of our visit for the installation of a new roof. We note that it did not re-open after the roof was replaced due to uncertainties over future service configuration. Members of staff from The Bungalow were redeployed to provide additional community day and community services.

**Boniface Unit, Crediton**

This was suspended for the whole length of our enquiry.

**Fernworthy Unit**

This had been suspended in late 2007 for refurbishment and we were given no clear date as to when it might re-open.
Issues of patient dignity and single-sex accommodation

In May 2005, the Department of Health gave a clear public commitment to eliminating mixed-sex accommodation for hospital inpatients. Three objectives were set for the NHS, designed to deliver single-sex accommodation. They apply to all NHS trusts providing inpatient accommodation. The objectives are first to ensure that appropriate organisational arrangements are in place to secure good standards of privacy and dignity for hospital patients; second, to achieve the Patient’s Charter standard for segregated washing and toilet facilities across the NHS; and third, to provide safe facilities for people in hospitals with mental health needs, which safeguard their privacy and dignity.

Single-sex accommodation is defined as separate sleeping areas for men and women, segregated bathroom and toilet facilities for men and women and, in those trusts providing mental health services, safe facilities for people with mental health needs.

This can take a number of forms. NHS trusts may provide single-sex wards, or a combination of single rooms and single-sex bays.

In September 2008, trust board minutes stated that “work is in progress with the Estates service to look at ways of improving the trust’s provision, in accordance with the Secretary of State’s directions.” Non-executive directors asked at that meeting if there were any reasons why units where there were two wards could not simply be separated to provide male and female accommodation. The board was assured that “all facilities were being surveyed to ensure assessment and mitigation of operational risks”.

The November 2008 Mental Health Act Commissioner’s report into the trust suggested that developments around single-sex accommodation would enhance facilities in older people’s mental health services.

In February 2009, the trust’s chief executive told the board that a large piece of work was underway to ensure single-sex wards, for which there was a timescale of June 2009. Due consideration would be given to issues of privacy but, in some areas, a major restructuring was not possible. When asked where the problem areas were, it was reported to the board that these were principally in older people’s mental health services.

We have noted and documented comments from staff across the trust in relation to struggles to maintain patient dignity by being unable to fully provide and guarantee single-sex accommodation.

Infection control

The trust received an unannounced inspection in January 2009 as part of the Healthcare Commission’s Healthcare Associated Infection (HCAI) inspection programme. The outcomes of the inspection were published in April 2009.

The inspection found that the trust was compliant with Duty 2 of the Hygiene Code. This states that the trust must have in place appropriate management systems for infection prevention and control. It was also found to be compliant with Duty 3, which states that the trust must assess the risks of acquiring hospital-acquired infections and take appropriate action to reduce or
control those risks. However, the inspection found that the trust was in breach of Duty 4, in that it was not providing and maintaining a clean and appropriate environment for health care. This was because it was not compliant with Duties 4a and 4c.

Duty 4a states there should be policies for the environment that makes provision for liaison between the members of any infection control team (the ICT) and the persons with overall responsibility for facilities management. At the time of the HCAI inspection in January 2009, not all of the policies for the environment made provision for liaison between the ICT and facilities staff. Duty 4c states that all parts of the premises in which it provides health care are suitable for the purpose, kept clean and maintained in good physical repair and condition. At the time of the HCAI inspection, the clinical areas on the four wards inspected were not kept clean or maintained in good physical condition. The Healthcare Commission asked the trust to ensure that these issues were addressed.

In our review of infection control at the trust covering the period of the enquiry we found the following evidence. In January 2006, the board approved two infection control policies to comply with the requirements of the Clinical Negligence Scheme for Trusts (CNST). In January 2007, the then director of nursing presented a revised Infection Control Policy in order to meet updated requirements of the CNST guidance. In September 2007, the trust board were informed that the Strategic Cleaning Plan – a requirement of the National Patient Safety Agency in determining trusts’ approach to cleanliness – complied with national cleaning standards, which contained 49 elements determined by the level of risk posed. The standards covered aspects ranging from commodes to ward walls. In January 2008, the chief executive reported to the board the assurance that the trust’s infection control committee had considered the findings of the Healthcare Commission’s investigation into Maidstone and Tunbridge Wells NHS Trust and had instigated actions in line with the recommendations of that report.

We noted that the following infection control audits had been carried out at the trust since 2006: Hand washing and Infection control (Rougemont Ward). It had also carried out the following trust-wide audits: Infection control (2006/07, 2007/08, 2008/09), Hand hygiene monitoring (2006/07, 2007/08, 2008/09), Antibiotic prescribing (2008/09), and Essential steps of safe clean care (2008/09).

**Overall assessment of cleanliness and infection control**

Our general view of the cleanliness of the units we observed during our announced and unannounced visits was acceptable with one or two exceptions – for example, the shared sluice between Westleigh and Rougemont wards and concerns that we raised with the trust over our observations at the David Barlow unit. Overall, we found the patient areas, toilets and bathrooms clean with no evidence of poorly cleaned commodes. Sluice areas we examined were satisfactory.
6. Staffing

Note: The National Service Framework for Older People (7.47 and 7.48) advises that core members of a specialist mental health service community should include:

- Consultant psychiatrists specialising in mental health problems in old age
- Community mental health nurses
- Clinical psychologists
- Occupational therapists
- Social workers.

They should include agreed working and referral arrangements with:

- Speech and language therapists
- Physiotherapists
- Dieticians
- Chiropodists
- Community dental services
- Pharmacists
- District nurses.

Findings

- The trust has undertaken some work to establish standard ward rotas, but this has yet to be fully implemented across the trust.
- The relative isolation of units from each other means that it is relatively difficult to move staffing resources from one unit to another.
- Staffing levels were the focus of savings in the trust financial recovery plan. We saw less evidence of focus in board papers on maintaining levels of quality of care.
- At the time of the incident, there was no consistent model of staffing at every older people’s mental health unit, although the trust has stated it is addressing this (see chapter 12).
- There was no uniform application of occupational therapy.
- While the costs of nursing and agency staff have fallen since 2006, the costs of senior management and management at the trust have risen.
- At ward level, we were repeatedly told that staffing numbers were insufficient.
- Concerns were expressed by members of staff about the quality of some agency and NHS Professional staff.
- A lack of appropriate medical cover at the evening handover period meant that, at some units, there was inadequate out-of-hours cover until the out-of-hours service came into operation, leaving staff and patients vulnerable.
- A reduction in inpatient staff had not led to a corresponding increase in community staff in all areas.
- There were variations in levels of community mental health staff across the trust, and levels were particularly low in North Devon.
There is no universally applied tool or national guidance for benchmarking staffing requirements in older people’s mental health inpatient units and community services.

The approaches that do exist tend to rely on professionals locally assessing ward activity alongside patient dependency, in order to arrive at a judgement as to the overall staffing numbers required. In determining staffing numbers, the trust should reasonably listen to the people actually on the ground providing the service, to gain the benefit of their experience of what is a reasonable level of resource necessary to provide not only a safe, but also an effective, patient care service.

The trust had undertaken some work to establish standard ward rotas. This attracted a lot of feedback from ward managers at the time. The trust used a rating scale to produce a headline figure for what the staffing establishment should be. We were told that a professor from Leeds University has been engaged to use dependency scales to represent the complexity of the client group of the older people’s mental health service.

To be included in the equation is the trust’s move to greater emphasis on services provided in the community. This has meant that the kind of patients who have been and will be admitted to inpatient units will be more acutely ill and require higher levels of nursing than in the past.

Examination of board papers covering the period of our enquiry indicated attention to staffing costs. In the board minutes of March 2006, it was noted that “although there had been improvements in reducing expenditure in recent months, particularly on agency staffing, the trust faced a likely overspend of £3.6 million at the end of the financial year”. In May 2006, the board minutes stated that “the use of medical and nursing agency staff has continued to reduce and represents a considerable success during the last quarter of 2005/06”. The trust informed us that the reduction in agency spend was achieved largely through the filling of vacancies.

A finance report to the September 2006 board noted an “under spend against a plan of £1086k for month 5, mainly relating to maintaining and managing the current level of vacancies. As previously discussed, vacancies are being systematically reviewed in performance meetings to determine backfill costs and whether different ways of working mean that they no longer need to be filled”.

In March 2007, the board was told that the trust “has the contracted level of manpower required to achieve its financial target. However costs are being incurred on backfill of vacant posts.

In September 2007, the director of finance reported that contracted staffing levels continued to reduce. Members of the board expressed concern and “sought satisfaction about processes around backfill of staff (i.e. decisions around filling or non filling of vacancies) bearing in mind the costs of using NHS Professionals”. In the same meeting, it was noted that establishment levels (i.e. substantive staff in post) was below target for the year. The shortfall was being met through the use of NHS Professionals, agency and overtime. It was noted that the workforce plan was in the process of being developed and this would inform recruitment processes.

In November 2007, it was reported that the trust’s target headcount was achieved ahead of plan, supporting delivery of the redesign and recovery programme and, in January 2008, it was reported that the trust would not expect staffing levels to fall any further. In January 2009, it was noted that “all directorates are performing well against planned expenditure but particular improvements were noted against medical staffing and agency spend”. In February 2009, the finance director informed the board that the trust was in forecast financial surplus of £1.9
million. However there were “outstanding concerns against overspending on in-patient wards and he pointed out the need to ensure optimum ward rotas”.

The trail of board reports indicate a sustained programme of cost reduction on the part of the trust to achieve financial balance and even surplus. We did not find similar emphasis in board minutes in relation to the board gaining assurance on the quality of patient services. The savings in staffing levels in the trust financial recovery plan was achieved through reductions in the network and number of wards. Staffing levels on the remaining individual wards did not decrease and the staff per bed ratio actually increased. However, the level of dependency of the patients being treated on them increased at the same time and the number of beds decreased as part of the reduction in the number of wards.

We looked at the relative costs of nursing staff against the trust’s spend on senior managers and managers for the years 2005/06 to 2008/09. Our analysis showed that while the spending costs for qualified nurses had dropped over that period from £26.1 million to £25.4 million and for unqualified nurses from £14 million to £12.5 million, the costs for senior managers and managers had risen from £4.5 million to £6.8 million (based on original information provided by the trust and including modern matron costs). The trust subsequently provided us with a figure excluding modern matrons. This showed that the costs for senior managers and managers increased from £3.6 million to £4.3 million.

While the costs for consultants throughout the trust had risen from £6.2 million to £7.5 million, there was a drop on spend on medical grades below consultant from £1.97 million to £0.88 million.

The trust informed us that, during the period under analysis (2005/06 to 2008/09), the trust’s income increased by 23%.

Our observations

Our impression as we visited the older people’s mental health inpatient units was of highly dedicated ward managers, nurses and nursing assistants working under constant pressure. On more than one occasion, we came across ward managers who were trying to do their best for their patients with too little resource and fearful that they had not covered every aspect of patient care and the management of their ward. The message from members of staff we spoke to on all the units was a need to have more staff on the wards.

Several members of staff told us that they did not feel that the staffing levels were sufficient, and were not safe given the unpredictable behaviour and potential for violence and aggression of the particular group of patients. Some staff and managers said that there was historically a lack of planning of staffing on units. On one unit, the lack of adequate staffing was described as holding back the unit, which would otherwise be able to deliver a good service. Other members of staff said that they had been calling for increased staffing for years, and some work had been done about two years previously to work out new rotas but nothing had come of it. To some, it seemed that only when the older people’s mental health service came under scrutiny following the raising of concerns at Harbourne did the trust finally acknowledge there was a need for extra staffing to ensure the safety of staff and patients.

We found too that members of staff were generally not satisfied with the care they were able to deliver. In the NHS staff survey for 2008, the percentage of staff feeling satisfied with the
quality of work and patient care they were able to deliver was 51%. This placed the trust in the worst 20% of mental health/learning disability trusts in England.

Given that all the older people’s mental health units are in isolated locations and away from support, staff concerns centred on insufficient staff numbers to ensure patient safety and to ensure quality. We were told of many occasions of ward managers having to step in to plug staffing gaps and there was widespread nervousness about having only one trained nurse on duty per shift, which was common. We were told of an instance when there was no access to out-of-hours emergency cover at night, when members of staff had had to lock themselves in the ward office for their own safety until help arrived.

**Lack of standard staffing model**

We noted a variable presence of such essential staff as ward clerks, allied health professionals (e.g., occupational therapists), nutritionists and psychologists. For example, on units where there was no ward clerk, duties such as booking in patients and obtaining the necessary records had to be done by already stretched nursing staff.

There were also comments from some staff that there did not appear to be a standard ward rota throughout the trust and, instead, staffing levels appeared to be based on historical arrangements with no set formula applied. We were told that the trust was addressing this and that some work had been done to establish standard ward rotas, which attracted a lot of feedback from ward managers. The system adopted used a quick rating scale to produce a headline figure for what the staffing establishment should be. We were told that the trust has not yet achieved standard ward rotas in all its units.

The variations in the numbers of staff per bed varied from lowest to highest in the trust’s older people’s mental health units as follows in the three-year period covered by our investigation:

- **In 2007:** Lowest 1.1 staff per bed (David Barlow unit): Highest 3.4 staff per bed (Harbourne).
- **In 2008:** Lowest 1.2 staff per bed (Redvers): Highest 2.8 staff per bed (Harbourne).
- **In 2009:** Lowest 1.3 staff per bed (The Bungalow and Rougemont): Highest 2.8 staff per bed (Harbourne).

The average number of staff per bed across all the older people’s mental health units rose from 1.5 in 2007 to 1.8 in 2009. However, this is in the context of a reduction from 158 inpatient beds in 2007 to 123 inpatient beds in 2009, based on trust figures.

**Levels of occupational therapy staff**

We found the level of occupational therapy staff to be inadequate in the trust’s older people’s mental health units. Too often we found examples of only part-time occupational therapy presence, which was insufficient to deliver a regular programme of activity for the patients. Several members of nursing staff we spoke to said that they did try to engage with patients when time allowed, but it was clear to us both from interview and from our own observations on the wards that the opportunity to do this was very limited. Too often, we observed patients sitting in their chairs with little activity being undertaken.
We actually became aware during some of our unannounced visits that patients were being engaged in some rudimentary activity, but we saw no evidence that it was part of a regular and concerted programme of patient activity and involvement. Given our knowledge of concerns about staffing levels, we could understand that members of staff would have little time to engage fully with patients.

We did come across examples of some activity and we were conscious in most units that members of staff were interacting with patients constantly. We also came across examples of patients at one unit who were going out to day centres, even where this meant that members of staff were away from the unit for a period in order to accompany them.

We noted that the trust has a lead occupational therapist. However, we were concerned that this post does not have line management responsibility for the trust’s team of occupational therapists. Instead occupational therapists report for supervision to the ward manager and into general management. There is no professional line supervision, thus weakening the overall role and benefit of occupational therapy within the trust. This may also make it more difficult to recruit occupational therapists interested in professional development.

We make our comments against the reality of more high dependent patients being admitted to wards but also in the light of evidence that the quality of stay of patients is enhanced if they are engaged and active in ward life, rather than just sitting around in chairs all day. Their levels of anxiety, confusion and potentially disruptive behaviour are likely to be reduced and their levels of wellbeing likely to be increased by greater levels of activity and involvement. Consequently, the trust needs to completely re-examine its arrangements for occupational therapy and patient involvement. It needs to consider more innovative ways of involving its patients in the day-to-day activities of ward life. Good examples of such activities can include patients becoming involved in the kind of activities they might previously have done at home as well as memory sessions, card games, music groups, gardening, baking and other leisure activities.

Access to other health professionals

We have already noted in our case note review that access to dietetics, physiotherapy, psychology and speech and language therapy seemed very sparse. During our visits and from interviews, we noted a low presence of these and other allied health professionals, plus access to physiotherapy and continence services. The trust told us that it refers directly to PCTs and acute trusts to provide these services. However, it is the trust’s responsibility to re-examine the arrangements for the adequate provision of these services.

Levels of community staff

We found large variations in the numbers of older people’s mental health community staff in the different locations in the trust. The ratio of staff to patients varies from 1: 13 in Mid Devon to 1:38 in North Devon. We were told by individual members of community mental health teams in all areas of the trust that there had been insufficient investment of overall staffing resource to cope with increased patient demand.

The trust has been reducing the number of inpatient beds in recent years (from 158 in 2007 to 123 in 2009) and bed occupancy rates have risen. These now regularly exceed 85% in some units. At the same time, the number of staff employed at the trust’s older people’s mental
health units has reduced overall, according to trust figures, from 242 to 215. Set against this, though reduced beds and reduced numbers of inpatient staff would mean the greater need for resource out in the community, the trust’s community mental health teams have not seen a growth sufficient to meet this need in all areas. However, the trust states that where the number of beds was cut, community team staffing numbers have been increased with no redundancies to achieve staff changes. Members of staff have been redeployed into community services wherever possible.

The caseload for community mental health teams has grown while the numbers of older people’s mental health community staff have fallen, according to trust figures. The levels of community mental health staff have in some cases stayed the same or fallen in some areas or at least not grown to meet this need. For example, the community team in Exmouth is the same size as it was in 1984.

With local variations the caseload for community mental health staff has risen from 14.7 cases per member of staff to 18.8 cases per member of staff. Within this average of 18.8 cases is a wide variation in caseload, depending on the individual team location, ranging from the lowest of 13.8 cases per member of staff in one team to the highest of 27.2 cases per member of staff in another team (2009 trust figures). Evidence provided by the trust shows that overall staffing levels for community mental health teams did actually grow from 141 in 2007 to 156 in 2008 only to fall back to current levels of 141 in 2009.

Similarly, a snapshot view of referrals to the community mental health teams of patients waiting to be seen has shown a steady increase (with periodic fluctuations) from 313 in February 2008 to 388 in June 2009.

**Agency staff and NHS Professionals**

We found mixed views from members of staff in relation to the use of staff from NHS Professionals (NHSP). There was recognition that there is a place for agency or NHSP staff to deal with periods of high pressure cover for sickness etc, but there were concerns where there was too much reliance on such staff, particularly where they were unfamiliar with the ways of working in the local older people’s mental health unit. Members of staff were more reassured if their agency staff were ‘regulars’ who had become experienced in dealing with the client group of the trust.

Some members of staff told us that NHS Professionals were poor at providing the necessary trained staff, and that agency or NHSP staff that had never been on a particular ward before would often be quite nervous since they did not understand the patients they were dealing with.

Key performance measures that were set out in the original contract between the trust and NHSP were met according to trust evidence. However, this level of assurance conflicted with the experiences of nurses “on the ground” who expressed high levels of concern over NHSP’s ability to provide temporary nursing cover to consistently meet patient care needs.

The trust set up a monitoring group to address high levels of concern at NHSP’s inability to provide staff to a satisfactory standard. In November 2008, the board were assured that NHSP met the core requirements of the contract with the exception of short notice requirements and the number of “deleted” requests, which indicated unmet demand. The trust’s spend on total
agency and NHSP staff for all of its services declined from just over 60,000 hours during the first quarter of 2006 down to 30,300 hours in the first quarter of 2009.

From interviews we conducted, there was a realisation at senior levels within the trust that there had been a heavy reliance on agency staff to meet the needs of the older people’s mental health client group. One director recalled that it was predominantly the older people’s mental health wards that were requesting more staff and that they relied heavily on NHSP. We were told that the trust did not implement a recruitment freeze, but that they did remove vacancies. Another director acknowledged an extensive use of NHS P staff and noted the strengths and weaknesses of doing this.
7. Line management and supervision

Findings

- Line management arrangements in the older people’s mental health services were complicated by interim arrangements, and inadequate due to vacancies.
- The trust failed to make substantive appointments to key posts and relied on interim managers for prolonged periods.
- Nursing leadership and supervision were inadequate.
- The trust failed to appoint its full quota of modern matrons to its older people’s mental health service.
- Arrangements for medical supervision and peer support of doctors and consultants were inadequate.
- The trust’s overall appraisal systems were unsatisfactory and the trust had no accurate figures of numbers appraised.
- The trust has lacked professionally qualified human resources input and influence at board level.

Overall management structure in the older people’s mental health service at the trust

In terms of line management, particularly in older people’s mental health, we found a picture both of complicated line management arrangements and a lack of capacity in older people’s mental health management. We found a management structure with a significant number of interim posts, many of which had been occupied for far longer than six months.

We were told that there had been numerous interim managers over recent years, many of whom only stayed for a temporary period before moving on elsewhere or returning to their host employer. We came across instances of short-term secondments that would only make a temporary contribution before the incumbent returned to their substantive post. We found more than one example, due to the lack of modern matrons, where ward managers were reporting directly to the general manager for older people’s mental health services.

The term “interim” generally means someone in post for no longer than six months and certainly no longer than 12 months. However, most of the interim posts we came across had been in existence for over 18 months and longer.

We identified from our own evidence and enquiries the following interim posts: interim director of nursing; interim director of operations and workforce; interim general manager for older people’s mental health services; interim director of business development; interim general manager south west Devon; interim organisational development manager; interim ward manager; at least two locum OPMH consultants for over 18 months and five years respectively; interim assistant general manager OPMH; interim community team leader; interim service manager; interim OPMH project manager.

One member of staff we spoke to said that this level of interim posts led people to accept constant change as the norm. We accept that in any changing organisation there will be a need
for flexibility and change, but we are concerned that having a considerable number of key posts as interim would prevent long-term ownership of responsibilities of those posts. The trust has informed us that maintaining this level of interim posts was a deliberate act, but we are concerned that this would hinder real development in trust services by individuals unsure of their permanent tenancy of such key positions.

One reason for the temporariness of so many posts appears to be the trust’s decision some time in 2006 to move to a permanent management structure based on network managers across the trust including network managers in the older people’s mental health service. Despite this plan the trust was unable to appoint to these roles due to the calibre of applicants and this led to a longer than expected interim tenure of posts. There has also been an additional layer of uncertainty as the trust has decided to move towards a new management structure based on clinical directorates,

Several members of trust management we spoke to recognise the disadvantages of having a large number of interim posts. The trust clearly underestimated the task of appointing to a new structure. It was recognised that interim posts had been a real issue in older people’s mental health services and it appears that this situation has gone on too long leading to claims that senior managers were rarely seen in older people’s mental health and there was a lack of stability. Issues outside of the direct clinical sphere were difficult to raise and effectively follow up.

Organisational and development strategy

The trust had identified a general need to develop leadership in its 2006 Organisational Development Strategy – 2006-09. In the trust board minutes of September 2006 the intention was stated to develop a new integrated management structure with the appointment of four new older people’s mental health integrated service managers from existing staff to cover both social care and NHS provision. This planned development was later withdrawn when Devon County Council decided to reconfigure its own services.

The trust has set out plans to develop along the lines of clinical directorates, with the older people’s mental health service being one of these.

Nursing leadership

Lack of a director of nursing

For a period of 19 months the trust lacked a substantive director of nursing following the departure of the previous incumbent on secondment to the strategic health authority.

The trust attempted to fill this gap with the appointment of an assistant director of nursing supplemented by the provision of nursing advice to the board by a professor from a neighbouring university on a part time basis. During this period there were two board meetings when there was no senior nursing representation. The former assistant director of nursing was involved in terms of giving advice but she did not fulfil the full director of nursing role. She told us that she had felt very new to the role and had lacked sufficient mentoring and support. Other members of staff told us that they did not think that this arrangement of assistant director of nursing combined with the external part time consultancy consisting of two or three days a month worked well.
The lack of a fully functioning nursing structure from board downwards with a lack of modern matrons in post meant that not only were individual units largely left to operate in isolation and with divergent practice without adequate nurse supervision, but also it meant that there was no professional structure or support within which nursing staff would have the ability to offer formal challenge to any practices that were of concern.

The trust has indicated that it experienced difficulties recruiting to the post of director of nursing, consequently changing the job title to that of ‘Executive Nurse’ as a means of stimulating new interest in the post. The post was appointed to in March 2009. The Executive Nurse, who has now been appointed as Director of Nursing and Practice is a member of the Trust Board and is responsible for professional practice in nursing.

We noted that the appointment of the Executive nurse, subsequently appointed to Director of Nursing and Practice has had a positive impact in terms of nursing leadership within the trust.

**Modern matrons**

Unlike the general adult mental health service, the older people’s mental health service did not have modern matrons. They are seen as a key link in the management structure, bridging both the need to provide effective management to a group of ward managers but also as a link in the chain to maintain and improve nursing quality standards. The older people’s mental health service still does not have its full complement of four modern matrons in post. At the time of the enquiry two modern matrons had been appointed. The trust had re-advertised the posts both internally and externally and was hopeful of making appointments. They stated that they intended to use the funding for the final modern matron post to provide specialist supervision and appraisal for ward managers.

The lack of modern matrons in post left older people’s mental health services at a disadvantage because there was a layer of coordination missing to get things done. We were told by a former interim director of nursing that this lack of staffing at the top meant there was a lack of time to visit all the older people’s mental health units and a lack of support (from the modern matron layer of management ) to ensure safe practice, service quality and improvement was actually being implemented. A business case was eventually put forward for a total of four older people’s mental health modern matrons, although the delay in appointing them has left the leadership structure incomplete. In addition we saw no evidence that the trust has clearly defined the role of its older people’s mental health modern matrons in contrast to those employed in the general adult service.

**Nursing leadership**

Effective nurse leadership is recognised as being essential in the management and delivery of change, the motivation of staff and in the maintenance of morale. National and local initiatives support the further development of nursing leadership, for example national nursing leadership programmes.

In 2006, a revised nursing strategy was presented to the board by the previous substantive director of nursing before he was seconded to the strategic health authority. The priorities identified for the future were: enhancing the quality of care (physical and psychosocial); strengthening nurse leadership; career framework – New Ways of Working; implementation of the chief nursing officer’s review of mental health nursing.

Subsequently the external nurse adviser to the board advised that some specific areas had been identified including: having sufficient nursing structure for patient activity during the day (some
clients could not make the best of their stay because of a lack of this structure); also a proposal to appoint nurse training posts to strengthen the nursing structure.

The lack of a substantive Director of Nursing in post for 19 months and also the lack of modern Matrons diminished the trust’s capacity to develop and carry through this programme until the current post holder was appointed. However we do recognise that the trust was able to take forward some work particularly on Essence of Care, which is a Department of Health programme aimed at giving doctors and nurses a structured approach to sharing and comparing good practice with a view to developing action plans to remedy poor practice.

**Nursing supervision**

Professional supervision of a nurse by a senior more experienced nurse is an essential element of maintaining professional nursing practice and developing new skills. It is an essential part of nurse leadership aimed at improving patient care.

Every ward manager and most nurses we spoke to said that they either never had or rarely had formal supervision. The reason for this was universally given as lack of time and resource and this cross references to lack of staff and a lack of a coherent and stable management structure within the older people’s mental health service. This has led to disempowerment of nursing teams. The teams in each older people’s mental health unit feel isolated and there is a real challenge for them to keep their knowledge and practice up to date.

The lack of a fully functioning Director of Nursing for 19 months had impacted on the whole nursing team of the trust in that decisions on care had been largely left to the medical team of doctors and that the nursing team overall had not been included in the expected level of multi-professional care planning for older people’s mental health services as well as generally throughout the trust. This had only added to problems in individual units such as Harbourne when there had been no effective nurse challenge to consultant decisions, for example. The trust chief executive when interviewed acknowledged a significant gap in nurse leadership during the period of no substantive director of nursing, which had not been sufficiently compensated for by having an assistant director of nursing acting up supplemented by an external nurse adviser reporting on nursing issues to the board.

**Medical supervision of doctors and consultants**

All consultants and staff grade doctors should be appraised every year.

We found that generally medical supervision of junior doctors tended to happen because they were motivated to seek this out as part of their training and development. The junior doctors are managed by consultants and an hour’s supervision is built into their job plans.

The picture in relation to medical supervision of consultants was less clear. Until recently the trust has relied on a model whereby consultants have been able to choose their own appraisers. This system appeared to be informal and individuals could ask a friend to complete their appraisal. This lack of a formal and robust approach was a factor in the lack of formal challenge to individual practices by older people’s mental health consultants coupled with their relative isolation. Although we were told that informal concerns had been raised by another clinician about practices at Harbourne there had been no formal action taken until the concerns were raised there.
A consultant in South Devon was appointed in 2009 as trust lead for appraisal and we were told that the system of consultants choosing their own appraisers should change by April 2010.

The trust has a policy for supervision. We were told that they were aware of problems in practice prior to the raising of concerns at Harbourne. The Director of Operations and Workforce told us that they had commissioned a major review of the supervision policy. They recognised that their supervision policies were not as good as they could be and if they had been a clearer picture of issues of clinical practice would have existed.

One of the non-executive directors we spoke to regarded supervision as a key area that the trust was still to effectively address. Another director told us that although an interim policy was in place for the previous year that stated that face to face supervision of a minimum of thirty minutes to an hour needs to happen for clinicians every month, this was not happening in practice.

Core standard 5b of the annual health check states that “healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership”. The trust has been declared non compliant against this standard in every year to present day since year 2005/06.

**Appraisal system for non clinical managers and senior managers**

We found the arrangements for the appraisal of non medical senior managerial, managerial and clerical staff to be unsatisfactory. We found that the trust had no reliable information as to the number of these staff that had received an appraisal in the past year or previous years. We were told that it relied on information from a self declaration survey, which was not a reliable measure. We were also told that the trust has four separate computer systems that might be used to collect such information.

In the latest NHS national staff survey (2008) only 58 % of trust staff said they had received an appraisal, performance development review or other review in the last twelve months. Set against a national average of 70% this result placed the trust in the lowest (worst) 20% of mental health/learning disability trusts in England.

Similarly, only 49% of those staff appraised said in the same survey that they had agreed a personal development plan as part of that appraisal, placing the trust again in the bottom 20% of similar trusts. Only 36% of staff felt there were good opportunities to develop their potential at work.

**Professional human resources input and influence at the trust**

When we interviewed members of staff employed in the trust HR department we made several observations. First there was recognition that the length of time interim arrangements had been in place was undesirable from an organisation efficiency point of view. There was also a recognition, particularly when the trust failed to appoint to its network manager posts due to lack of quality in its internal candidates that the trust should at that time have sought to recruit external candidates. In addition we noted a recognition that the trust’s appraisal system was neither robust nor being rigorously applied to all members of staff.
It did not appear that the HR voice had received sufficient hearing at the highest levels of the trust. Had this been the case, an over reliance on trying to grow and develop its own members of staff to the exclusion of outside applicants might have been identified as a potential problem earlier. We noted a sense of frustration in some HR staff that were professionally qualified and could see these issues but felt that these concerns were not necessarily being raised with sufficient voice and authority at board level.

When we spoke to a member of the non-executive director team there was a recognition that this direct board representation of HR had been lacking and it is our view that had there been a professionally qualified director of HR on the trust board some of these issues would have been recognised sooner and some of the seeming lack of direction and achievement in seeking a new trust management structure, robust appraisal and development system and an effective leadership structure might have been overcome.
8. Training

Findings

- The trust had successfully raised its uptake of mandatory training.
- Despite this, we came across members of staff who were not confident in the practical application of care under the Mental Health Act and Mental Capacity Act.
- Levels of training beyond the mandatory level were less developed.
- The trust had placed extensive reliance on e-learning, with few alternative methods of learning.
- There were gaps in opportunities for nursing staff to develop.

NICE clinical guideline 42 – (Dementia, supporting people with dementia and their carers in health and social care, November 2006) states that “health and social care managers should ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia care training (skill development) that is consistent with their roles and responsibilities.

The trust has made progress in its achievement of 70% of staff being recorded as having received their mandatory training necessary to undertake their duties, starting as it did from a very low base. Uptake for mandatory training had been very poor and it had failed this annual health check core standard in the year 2007-08. The trust needed to take remedial action and, as a result, we conclude that the trust’s focus has been very much on mandatory training.

The trust has relieved on e-learning to the extent that its former classroom based training has been largely disbanded. We were told by a trust manager that attendance at the former classroom learning had been relatively poor and the undoubted advantage of e-learning is that it can be accessed by individuals in theory at times to suit them.

Training had been on the trust risk register for some time. In March 2007, it was rated red (most serious). The board was assured then that a number of issues were being looked into; including what was essential for individual staff roles, effective delivery, delivery methods and capacity to release staff. Board minutes of June 2008 stated that concerted efforts to increase uptake of compulsory (mandatory) training had been made over the previous quarter. This had been assisted by the introduction of e-learning modules.

Some staff told us that they had felt unsupported in gaining the necessary skills to use the e-learning system. Some had never used a computer before and were not offered IT training by the trust prior to the introduction of e-learning. Others were taught informally by other staff on the same unit how to use the system. Others reported that finding the time to do the training was the main problem in completing e-learning and the best time to do this was often on a night shift or on days off. Others reported limited access to a computer on the ward to carry out mandatory training and some accommodation to do this in private undisturbed was limited though not in all locations.

We were shown schedules of mandatory training and the records of members of staff who had undertaken this. We were shown similar schedules and plans for other training such as development training and desirable as opposed to mandatory training but these were paper schedules and plans and not training that was being actually delivered.
Members of staff told us that they lacked opportunities to go on training courses other than mandatory training. This was due to both staffing and time constraints as well as availability. There was a lack of emphasis on development and there were problems with National Vocational Qualification (NVQ) completion. Examples given to us were the lack of availability of anyone to act as an NVQ assessor. Some members of staff said they had been waiting for up to two years to start an NVQ relevant to their job.

We were also told that there was a lack of an overall training and development structure within the trust and this meant that members of staff were not able to take advantage of opportunities that might be available. It was known that the Strategic Health Authority has funding for degree and masters level courses but we found no knowledge of anything below this level. Degree courses were open to nurses. However there was no uptake by any member of staff in older people’s mental health at the trust for relevant degree courses in dementia care or specialised care of older people. The reasons for this were lack of communication of what was on offer and the lack of a bridging diploma level funding. Several nurses we spoke to either said that they did not think there was any additional training available or were not aware of any. However, in a statement to us, the Strategic Health Authority said that a joint investment framework agreement was in place between the SHA and the trust to provide funding for NVQ programmes not covered by local skills council funding.

During our initial inspection of the older people’s mental health units, the Mental Health Act Commissioner observed that while there was superficial knowledge amongst members of staff in relation to both the Mental Health Act and Mental Capacity Act, there was less satisfactory knowledge in relation to how these acts should be applied in nursing and medical care on the wards.

The Mental Capacity Act 2005 for England and Wales came into force in 2007. It provides a framework to empower and protect people, aged 16 and over, who may lack capacity to make some decisions for themselves. This may include people with dementia, learning disabilities, mental health problems, and stroke or head injuries as examples. The Act covers all major decisions a person may make including decisions and consent with regard to health care treatment. It is based on five key principles, namely:

- A presumption of capacity to make decisions unless proved otherwise.
- Individuals being supported to make their own decisions.
- An individual having the right and capacity to make an unwise decision.
- Any act done on behalf of an individual lacking capacity being done in that person’s best interest.
- Any such action to be the least restrictive of an individual’s basic rights and freedoms.

Amongst its provisions is the duty to consult people who know the person without capacity in order to determine their best interests. Where there is no-one to consult, and the decision is about serious medical treatment or about where to live, there is a duty to appoint an Independent Mental Capacity Advocate (IMCA).

The Mental Capacity Act also includes provisions to cover lawful restriction of liberty, and the Deprivation of Liberty Safeguards to address those circumstances where a person without capacity is restrained or restricted to the point of health or care workers having complete and effective control over a person’s freedom to act.
We have examined the workings of the trust to see how far the Mental Capacity Act has impacted on the trust’s enabling of empowerment to patients to be fully involved in decisions about their care and treatment, and for others to be involved in decisions about best interests. Many of the patients either observed on our visits or referred to in our case note review would appear to lack the capacity to consent to the treatment they were receiving. We have noted that we observed relatives and carers of patients on the wards we visited and that they appeared to be actively involved in the care of the patient close to them.

There is an area devoted to resources related to the Mental Capacity Act on the trust intranet and members of staff have been made aware of this by email. One nurse we spoke to did not consider this to be adequate. Several members of staff we spoke to said that there was no training available for the Mental Capacity Act other than the mandatory e-learning and some felt that they had to undertake mental capacity assessments without adequate training. Some people were trained in the actual legislation when the programme of assessments was rolled out but they were not trained in the application of the act.

A trust manager acknowledged that safeguarding training including mental health act and mental capacity act assessments needed to be strengthened in the trust. The initial introductory training provided the framework to the acts without necessarily embedding it into practice. Each member of staff had recently been provided with bullet points of the mental capacity act via payslips but it was acknowledged that they were still light on detail with reference to how services can respond to various questions of practice.

Some members of staff who had undergone a morning of Mental Capacity Act training said that they still found the act difficult to get to grips with and staff would find it daunting until they had used it extensively in practice. The Director of Workforce and Operations said that the trust was currently assessing how to use the act.

Many members of staff we spoke to said that it was often difficult to access training due to lack of protected time and lack of monetary resources. Examples given were lack of staff available to cover an individual wishing to undertake training; no budget available, lack of clinically based training – for example where previously CPA and risk training had been delivered centrally by the trust with staff updated every three years, this had now been suspended and the trust were looking to provide this locally, but this was not available.

We were told by trust managers that the previously dispersed training budget had been centralised in order to make better use of the spend available. This coupled with the emphasis on mandatory e-learning and the lack of control of local managers on even a limited training budget appears to bear out the complaints of members of staff that there are generally no training opportunities available outside of mandatory e-learning. We also put it to the director of finance that members of staff were telling us that protected time had been removed from training budgets as a contribution towards the financial recovery of the trust. He denied that this had occurred.

From the trust board minutes of July 2007, a non-executive director asked about the risk management of training particularly as the budget for non-compulsory training had been reduced in the previous year. The director of workforce and operations confirmed that compulsory training was a key priority for the trust and that all other training needed to link with service objectives. The learning and development team was working in partnership with the professions group of the clinical cabinet to identify what was needed so that non-compulsory training would reflect the priorities of the organisation.
In September 2007, a non-executive director expressed concern at the trust board that the audit of staff training needs was not complete. The answer given to that question was that Heads of Professions were leading a group to ascertain “appropriate skill mixes and to scope out development”, not that the audit of staff training needs would be completed.

Levels of training uptake

From the National NHS Staff Survey 2008, 77% of the staff at the trust said that they had received training, learning or development in the last 12 months, which had helped them to perform their jobs better, stay up to date with their jobs or stay up to date with their professional requirements. The trust’s score was in the lowest (worst) 20% of mental health/learning disability trusts in England.

Efforts had been made to overhaul training record keeping at a local level. In recent months ward managers have been receiving a spreadsheet with the names of their members of staff and the training they have received. The spreadsheet also provided details of what training each individual member of staff still needs to undertake. This makes it easier to identify overdue training.

At board or trust level, despite having centralised the training budget, there is no single monitoring tool available. This is due both to geographical diversity and also the fact that the trust inherited four separate computerised records systems. The amalgamation of these systems or their replacement by one single system may be some way off. Until that happens the trust finds it difficult to monitor the success or otherwise of its training programme.

Comments and conclusions

The trust clearly needed to ensure satisfactory levels of mandatory training for its staff and it has made good progress in doing this. However it now needs to concentrate on embedding that training. It needs to undertake further more detailed training on the practical applications of the mental health act and the Mental Capacity Act in a health and care setting. This needs to cover all nursing and medical staff.

In commenting on our report, the Department of Health has stressed the importance of members of staff understanding the requirements of the Mental Capacity Act in relation to capacity assessment, particularly when working with families and carers of patients and in relation to patients who cannot communicate. Where patients have no immediate family or carer to act in their interests it is important for members of trust staff to understand that they have a duty to consult the Independent Mental Capacity Advocate (IMCA) service set up under the Mental Capacity Act. Its purpose is to help vulnerable people who lack capacity to make decisions about NHS and local authority care and who have no family or friends to act for them.

It needs to translate the paper plans that it has for non mandatory non compulsory training into concrete action and actual training courses.

It needs to complete a training and development needs assessment for every member of trust staff and to tailor its training strategy and plans to those needs bearing in mind the shift of emphasis from inpatient services to community.
In developing its training strategy it needs to ensure that it builds in a staged approach to ensure that staff are able to move from one level of training achievement to another i.e. from basic mandatory, through NVQ, diploma to degree and masters level.

It needs to ensure training resource both in terms of protected time, financial support and sufficient back up staff to enable training plans and individual training and development to actually occur.

The trust needs to develop a centralised database of training completed, training required and courses available.
9. Culture of the older people’s mental health service and engagement with people, carers and families

Much of the culture of the trust is described in other areas of this report. However, the following are additional findings arising out of our enquiry.

Findings

- At the time of the chief executive’s arrival, there were problems in the trust’s culture. It had had a previous review of bullying and harassment (published in January 2006). There were also problems of a lack of engagement of medical staff.
- One result of this had been a determination on the part of the chief executive and board to encourage a culture of openness.
- The isolation of the older people’s mental health units, both from each other in terms of geographical distance and from their incarnations as former trusts, has led to diverging practices, which the trust has had limited ability to unify, improve and develop.
- Units isolated from trust headquarters were operating in almost a self-governing mode of independence.
- The trust’s relationships with partner agencies had been complicated by differences in approach to older people’s mental health.
- In the culture of openness, the trust has accepted the shortcomings in its older people’s mental health services and is actively seeking to remedy this through its redesign task group.

The trust’s chief executive explained the position that he inherited when he came to the trust in April 2005. They were having financial difficulties, were being investigated for bullying and harassment, and there were difficulties with Standards for Better Health. The trust had been given notice by multi-agency partners that interagency working relationships were not good.

The outcome of a bullying and harassment review revealed that there were deficiencies in HR, a lack of clinical engagement and a culture of fear. It took a while to establish the extent of the financial deficit, which was £12 million. He said that there was also insufficient clinical governance.

The trust has spent recent years concentrating on its adult mental health service following the triple suicide of three adult mental health patients. The aftermath of this event led the trust to redesign its adult mental health service.

Members of staff we spoke to said that as a result of this the trust had “taken its eye off the ball” in relation to the older people’s mental health service. Several members of staff described the older people’s mental health service as the ‘Cinderella’ service or ‘poor relative’. Despite ample opportunity, following the Sainsbury Centre review five years ago, the trust has failed to take advantage of this opportunity.

The trust has a large number of groups and committees, for which it is not always easy to identify their purpose e.g. the Clinical Cabinet. There appeared to be an overlap of responsibilities in some cases and it appeared that some committees or working groups had
been formed in an immediate attempt to solve a problem but that there was no overall strategy or framework within which to lodge these committees. An example of this was the various implementation groups that had been set up following the publication of the Sainsbury Centre report. We saw the minutes of these meetings and noted that there was a real determination on the part of the members of staff involved to make the recommendations into reality. However in the longer term their effectiveness started to recede and the practical application of those recommendations was patchy.

In many of the meeting minutes that we reviewed (e.g. board minutes) it is typically the case that older people’s mental health as a service is not discussed explicitly and it remains unclear what the service in question was that was being discussed.

Several members of staff spoke of changes being implemented quickly at short notice, without communication as to why these changes were taking place, or of the overall strategy within which they were occurring. These piecemeal decisions were often confusing to members of staff.

For example, in December 2007 the Fernworthy unit was closed for refurbishment and remained closed throughout the period of our visits to the trust. We were told that in fact there were also problems with renegotiating the lease for this unit from the neighbouring trust whose building it was. Also during the course of our enquiry the unit at the Bungalow, Honiton was suspended in order for a new roof to be installed. This had placed severe pressure on its neighbouring unit to accommodate patients. Previously there had been alternative bed availability/provision in three neighbouring units, which was not now available. Two of these units had been reclaimed by the PCT and subsequently closed.

Members of staff we spoke to expressed frustration that many of these suspensions of units were communicated at short notice with a lack of planning resulting in lack of availability of beds when needed. There is evidence that bed occupancy rates had risen substantially from 2006 to 2009 with several units showing occupancy rates in excess of 85% for over 12 months.

**The ramifications of isolation**

There are significant distances between the units. A return visit from the trust headquarters to north Devon will take up most of a working day. The sheer geographical size of the county area of the trust meant that we did not gain a sense of a single identity and, while other areas demonstrate different styles and cultures but can be recognised as a whole we sensed that members of staff tended to identify with their own locality for example, North Devon, East Devon, South Devon, Exeter and mid Devon. This identification was strengthened in instances of working links, for example in the case of pharmacy arrangements with other trusts that were based on the above localities. The former commissioning arrangements of the seven former PCTs for the services of the trust also emphasised this locality based mentality.

Members of staff at many of the older people’s mental health units identify themselves as being part of the unit as opposed to the trust; something indicative of the close, supportive environment engendered within the units. Though lacking in formal support such as appraisals, unit staff repeatedly speak highly of their ward managers. Converse to this, ward staff feel isolated as a unit, separate from the central trust and identifying themselves as knowing little of the goings on beyond their unit. Equally there is little communication between units. Confusion regarding the future of the older people’s mental health units (in terms of closure and
refurbishment) was apparent in staff across the units. Failure on the part of the trust to communicate messages to staff across the county has left individuals feeling unsupported as a unit with little trust 'identity'.

Equally the lack of management across older people’s mental health has left ward managers feeling isolated and unsupported. They themselves have not been provided with management or supervision and have been largely left to run the units as they choose. In cases such as Abbotsvale and Melrose, this has not caused evident problems, however site visits to David Barlow, Harbourne and Rougemont all revealed problems; this is not to suggest that the Ward Managers at these units were not performing to the standard of those at Abbotsvale and Melrose, rather that a number of factors – including the patient group (e.g. functional) – have created difficulties that have not been addressed. Indeed feedback from unit staff and CQC external advisors was generally very positive in relation to the ward managers.

**Community mental health teams and approved social workers**

The isolation of units is mirrored in that of the isolated Community Mental Health Teams. (CMHT) Whilst feedback (from inpatient units) in relation to the community service is good, members of staff reported it to be over stretched and under resourced. The removal of the dedicated social workers from the team has had a negative impact both in terms of lessening links with Social Services and putting more pressure on the CMHT service.

The trust maintains that though they were in discussions with Devon County Council regarding the removal of social workers into Complex Care Teams (CCTs), a timeframe was never set. Despite this, discussions had been taking place since 2007. There is no evidence of any preparation for this change, the knock-on effect of which has been delayed discharges of some patients.

NICE guidelines¹ (2006) state “Health and social care managers should coordinate and integrate working across all agencies involved in the treatment and care of people with dementia and their carers, including jointly agreeing written policies and procedures. Joint planning should include local service users and carers in order to highlight and address problems specific to each locality”.

In addition to social worker access diminishing, the Community Mental Health Teams are largely responsible for providing crisis cover for older people’s mental health as a result of there being no formal Crisis Resolution Service for older people’s mental health. The trust Crisis Resolution Team caters to those under 65. Those interviewed from the Crisis Team advised that they will not accept patients over 65. As a result of this it is the responsibility of the CMHT staff to get the patient admitted (if necessary), typically through the local GP. Leading from this, out of hours, there is no form of Crisis cover in older people’s mental health. The Devon Older People’s Mental Health Development Programme 2005 to 2010 recommended both integrated community mental health teams and appropriate access to crisis resolution teams, neither of which the trust has addressed. The trust has argued that plans changed following the creation of complex care teams; however there is no evidence of attempts of integration either before or after this.

It is unclear how the CMHTs will manage in light of future unit closures and service reconfiguration.

¹ Dementia – Supporting people with dementia and their carers in health and social care
Multi-disciplinary team working

It is not only access to social workers that the units are lacking. Interviews with staff revealed a lack of multidisciplinary team input in general. Access to Occupational therapists is limited and they themselves state that they are under resourced. The Practice Manager for North Devon advised of lengthy waiting lists for OT support. Leading from this, Devon County Council has advised that it is their intention to reduce the number of OTs in favour of social workers. Similarly, there is very little psychological input on the units, e.g. the Lead Psychologist for North Devon has been off sick for nearly a year. The Head of Psychology and Psychological Therapies cited long waiting lists within the community for therapies. The trust is aware of this gap in services – The Director of older people’s mental health services informed the CQC that not all units are operating an MDT model – however there is little evidence of any attempts to address this.

The National Service Framework for Older People (2001) details the importance of patients having access to a multidisciplinary team in view of receiving the most appropriate assessment and relevant care; equally decisions pertaining to long term care should be based on a multidisciplinary assessment.

Carer involvement

We found evidence that carers and family members were regularly involved in care decisions and we noted a commitment from members of staff to the care of their patients. On our visits to the units both announced and unannounced, we came across patients sitting with their relatives and their presence appeared to be welcomed by members of staff on the wards.

At the beginning of the enquiry we invited interested parties, including relatives of people who use services, to tell us about their experience of the trust’s older people’s mental health service. During some of these interviews we found evidence of individual families expressing concern about care decisions in some cases. We followed these up and found that most related to individual concerns about care decisions made by individual consultants. We feel that this further illustrates the trust’s lack of peer review and control of individual consultant practice. This isolated decision making left the trust vulnerable to not knowing what care decisions were being taken under its authority. Most of the complaints we were told about during these interviews were already the subject of formal complaints with the trust and consequently as an organisation we do not become involved in such ongoing work.

The trust’s relationship with partner agencies

Prior to the formation of one primary care trust for Devon (excluding Torbay), Devon PCT, there had been a legacy of variations between the seven former PCTs, with differences in approaches to how the trust’s services were commissioned and delivered. There were also differences in approach between the PCT and Devon County Council about strategic commissioning. In the view of one member of PCT interviewed, it was difficult to balance the tension between these two different approaches. Another member of PCT staff suggested to us that historical differences in different PCTs’ commissioning arrangements had affected service provision at the trust, although there was more of a commitment to improve services now. The situation was
more cohesive in Torbay where, because of its unitary authority status, there was greater natural cooperation between the health and social care commissioner and providers.

Devon County Council told us that there is a highly regarded joint agency commissioning strategy and action plan that has received national recognition and reflects the joint agency approach in Devon between the NHS in Devon and Devon County Council, and includes a joint Commissioning Manager for older people’s mental health services.

Once the concerns were raised at Harbourne, Devon PCT, in whose area Harbourne was, responded to safeguarding of patient issues and had taken necessary steps to conduct audits at the unit before the issue was escalated to the Care Quality Commission.

**Performance management of the trust**

We asked South West Strategic Health Authority (SHA) and Devon Primary Care Trust (PCT) about performance management arrangements that were in place for the trust.

A range of routine performance monitoring processes for all NHS trusts, including Devon Partnership NHS Trust, was in place. These included regular reviews of corporate performance, the serious untoward incident process for safety issues and the regulatory processes.

Performance monitoring of Devon Partnership NHS Trust was conducted by the lead commissioner, Devon PCT. The PCT confirmed that the SHA was invited to attend and contribute to the PCT-led contract management discussions to discharge their performance responsibilities and the PCT and SHA met periodically to discuss any issues of concern. The SHA sent us samples of notes from performance management meetings held in 2006 with Devon Partnership NHS Trust and from similar performance management meetings held with Devon PCT in 2007.

The routine processes did not identify the issues at Harbourne prior to the concern being raised. However, after the concerns were raised at Harbourne, there was an increase in monitoring of the trust by the SHA. There were regular meetings with the trust and all partner agencies to discuss serious incidents and to monitor safeguarding actions. Events, action plans and progress was reported at these meetings between January and June 2009.

The SHA sent us an example of notes of a formal performance review meeting, which they attended, held by the PCT with Devon Partnership NHS Trust in December 2008. These notes were short descriptions of current performance. The issues covered included performance against targets, financial performance, the trust’s foundation trust application and the potential safeguarding issues at Harbourne.
10. Clinical governance

There have been many definitions of clinical governance, including:

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."


The Department of Health’s Standards for Better Health gives a broad framework to implement clinical governance issues such as risk, patient safety, patient experience, evidence based practice, audit and the care environment.

Clinical governance should not, in our opinion, be viewed in isolation from the rest of the trust’s management processes. It relies on and should be underpinned by effective management structures, adequate staffing, robust clinical supervision, clear models of care, a suitable care environment, efficient performance appraisal and development systems and training provision that enables members of staff, both clinical and non-clinical, to carry out their roles effectively and ensuring the maximum quality of patient care and patient safety. Our comments in this section should be taken therefore in the context of the comments we have already made on the above areas.

Findings

- The trust’s overall clinical governance arrangements were not sufficient for the board to be assured of the safety of patients and quality of care.
- There was generally a good understanding and operation of local governance arrangements and incident reporting from the ward staff we interviewed.
- The understanding of corporate trust clinical governance arrangements was unclear among members of staff.
- The complicated system of groups and forums was difficult to understand and difficult to trace accountability.
- We could not find a clear line of accountability from local systems for clinical governance up to the trust board.
- At the time of the enquiry, the trust lead for clinical governance was not a full board member.
- Lack of effective clinical supervision, lack of historic effective medicines management, fragmented and changing management structures meant that the clinical governance structure was operating in isolation and without these supporting mechanisms.
- The trust’s clinical cabinet was regarded by the trust as the clinical governance committee, but it was not fulfilling this function.
- There was confusion at all levels in relation to the respective roles of the clinical cabinet and the trust’s quality and safety committee.

In relation to older people’s mental health governance arrangements, we found a variation across the trust, although generally local governance arrangements were in place. There was a lack of clarity around sharing of responsibilities especially between network and locality.
managers and ward managers. This fragmentation, the temporary nature of the management structure that we have noted elsewhere, a lack of middle management (in some cases between ward manager and general manager) plus geographical isolation and a lack of standard medical input meant that it was less easy to monitor clinical governance arrangements.

The trust has recently attempted to bring more uniformity of approach in its different locations by stimulating local governance through a fortnightly brief for staff from a newly formed serious untoward incident review group. This briefing was an attempt to overcome the fact that the group did not have clear ways of sharing information with those not involved in a given incident.

Some members of staff we spoke to described their concern that recently separate monthly older people’s mental health clinical governance groups had ceased as a separate entity involving clinical team leaders, ward managers and locality managers. These were felt to be very good but appeared to have been lost and there now appeared to be confusion over exactly what the clinical governance structures were in the trust and what the reporting lines of the remaining local governance groups were. Concerns were also raised that there did not appear to be a robust system in place for the implementation of NICE (National Institute for Health and Clinical Excellence) guidance.

We asked for and were sent by the trust minutes of local governance meetings, which indicated that local clinical governance structures were in place and were relatively easy to understand. They were based on what had been in existence in each locality for some time and as such differed in content of meetings but there was a degree of uniformity of the overall arrangements.

We noted that local governance groups worked separately from each other due to the distances involved between localities but we could find no clear connection between them and any central trust function for the overseeing of clinical governance across the organisation. The only exception to this was that we became aware that individual managers involved in clinical effectiveness, risk and audit, for example, bridged both local and trust wide arrangements but this was more in an individual liaison function rather than a formal local committee to central committee accountability.

We found that members of staff working in these clinical effectiveness and risk roles in the trust appeared to have a good grasp of what needed to be done but were frustrated by the lack of effective systems to enable them to feel as confident as they should around overall clinical governance and compliance.

Clinical cabinet

The clinical cabinet was established in 2006 to increase the level of clinical engagement primarily of the trust’s consultants and was recognised as the de facto clinical governance committee for the trust early on. Several members of staff in interview independently identified it as the trust clinical governance committee. The chair of the clinical cabinet, the director of research and development was identified as the trust lead for clinical governance. He also attends the trust quality and safety committee. He is not a full member of the board but attends board meetings.
We asked the trust to provide us with the minutes of the clinical cabinet. The trust’s response was to send us a series of high level bullet point outcomes from each clinical cabinet meeting. We concluded that these were the only outcomes of the clinical cabinet and began to realise that it was not functioning as a standard clinical governance committee for the trust. Separately, the NHS Litigation Authority had rejected the trust’s clinical cabinet as an appropriate committee for risk in December 2008. It stated that the terms of reference for the clinical cabinet did not contain the minimum requirements relating to the required frequency of attendance by members and the requirements of a quorum.

There appeared to be widespread confusion over the respective roles of the clinical cabinet and the quality and safety committee. We were given different accounts of where local clinical governance committees reported in to. We also detected confusion over the respective roles of the director of research and development, the trust medical director who attended the quality and safety committee only and the Executive nurse. Attendance at both committees appeared to be relatively fluid and, despite the assurance by one senior member of the trust that they thought all aspects of governance were discussed somewhere in the trust we gained the impression that this structure was one that had evolved “organically” without too much strategic thought and attention to accountability.

We appreciate the merits of using a clinical cabinet as a means of increasing clinical engagement when there was a clear need to do so. However, its remit should not have extended to be the trust clinical governance committee when clearly it was not operating as one.

Risk

Findings

- The trust’s risk register was too large with risks remaining on it for prolonged periods and at an inappropriate level.
- There did not appear to be a planned process to have the issues addressed effectively and at an appropriate level according to the nature of the risk.

National Institute for Health and Clinical Excellence (NICE) guidance on dementia

The NICE-SCIE Guidelines on Supporting People with Dementia and their Carers in Health and Social Care (2007) outline a number of factors that can affect individuals, their behaviour and their care. These are listed below in the following extract from the guidelines:

“Managing risk
Health and social care staff who care for people with dementia should identify, monitor and address environmental, physical health and psychosocial factors that may increase the likelihood of behaviour that challenges, especially violence and aggression, and the risk of harm to self or others. These factors include:

- overcrowding
- lack of privacy
- lack of activities
- inadequate staff attention
- poor communication between the person with dementia and staff
- conflicts between staff and carers
- weak clinical leadership.”
The trust’s Risk Strategy, Policy & Risk Assessment Process outlines the responsibilities for the management of risk, health and safety of all people who use services, staff and visitors, including taking appropriate actions to mitigate the risks identified. In relation to the management of risk the trust report that details regarding the assurances and controls in place, gaps in assurances and controls and action plans can be found within the Assurance Framework Document.

We examined the trust risk register at various points in the three year period 2006 to 2009. We found the same items on it over this period and many were largely rated the same level of risk at the beginning of the period as at the end. The Risk Register was very long and early on in this period we observed that the issues were not segregated into topic areas, for example clinical risks were not separated out. We found no documentary evidence of actions taken against each risk to address the issues and remove them.

Later on risks began to be segregated into appropriate areas such as clinical risk, human resources, governance, estates, finance, information technology etc, but again found that issues seemed to remain on the risk register for too long without mitigating action. In contrast medicines management did not appear as a risk on the early risk registers but was visible though from 2007 onwards.

One director told us in interview that risks ought to be divided into high level strategic risks to be dealt with mainly by the board, and also operational risks that, according to the level, would be dealt with at either trust executive level or local management level and clinical risks that would be dealt with at various levels of the trust’s clinical structure. However we are not sure how far this understanding and interpretation is more widely appreciated and we did not see during our enquiry that the risk register had been changed to reflect this thinking.

We would have expected to see more devolution of accountability for risk to either localities or, in the future to clinical directorates, with only the key trust risks being identified on the central register. We would also expect to see in board and other documentation clear actions taken to mitigate those risks and remove them. The devolution of risk would also depend on their being a strong solid management structure in place to progress the issues.

The trust reports that the risk register is updated regularly and is made available to the Trust Board, Audit Committee, Quality & Safety Committee and the Clinical Cabinet. The risks contained on the register are identified by a variety of processes including, incident reporting, complaints and claims analysis, local risk registers, audit reports, external assessments, and inspections.

In the minutes from the November 2008 meeting the trust reports that they will be assessed against the NHS Litigation Authority Risk Management Standards on 2/3 December 2008 at Level 1, against a total of fifty criteria within five risk management standards. The March 2009 minutes report that the trust successfully achieved Level 1 compliance. We note that it was in this assessment that the NHSLA did not view the clinical cabinet as an appropriate committee for the management of risk.

The trust reports that the Risk Team are working to develop an e-learning package for the assessment and management of clinical risk. They anticipate that this will also identify other complimentary clinical risk training that will be required and delivered in 2009/2010. Additionally the state that the Risk Team will further develop mechanisms for the
communication of lessons learnt; regular communication through established channels and fortnightly safety briefings.

In March 2008, the trust appointed a clinical risk manager due to the fact that it recognised that its risk management process was not particularly focused on clinical risk. Soon afterwards a small group was formed to meet fortnightly with the idea of bringing about immediacy around responses to serious untoward incidents and that this group reports bi-monthly into the trust quality and safety committee. We were told by a trust manager that this group was formed because the already existent serious untoward incident group, although clinically strong, lacked the key players to influence the organisation.

**Audit**

“Clinical audit involves systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient” (Department of Health, 1993).

A more general definition is that it is a process by which clinicians and managers assess, evaluate and improve their processes with the aim of improving quality of care for patients. Given that this will involve all trust activity one would expect to see a detailed programme of audit in place based on structure of the organisation, its processes, its known risks and incidents and its overall drive to improve standards.

It should follow a process of identified need, researched criteria and standards required, an information gathering process to ascertain current standards, assessing current standards against required standards and action planning to overcome the shortfall in standards.

**Findings**

- While the trust had the necessary policies in place around audit we did not find sufficient evidence that there was a trust wide planned approach.
- The level of audits was relatively small in number.
- We did not see evidence of serious untoward incidents feeding into audit programmes.
- Audit did not appear to be linked to the risk register or serious untoward incidents.
- The trust has embarked upon a programme of regular clinical and non clinical walk-around audits.

The trust carried out an audit of its processes for reviewing serious untoward incidents (SUIs) in the financial year 2008/09. According to the trust the audit identified feedback mechanisms in relation to actions initiated to reduce harm or reduce the likelihood of recurrence and communication of lessons learnt as areas that could be strengthened further. We examined the list of audits undertaken in this period. They covered patient discharge summaries, suicide prevention, audit of section 17 leave forms (allowing detained patients to have leave of absence from the ward) audit of Mental Health Act Section 132 as part of an ongoing cycle of audits against different parts of the Mental Health Act, an essence of care audit and three audits that resulted from the original raising of concerns at Harbourne but which were trust wide. These were first: a peer walk around audit designed to monitor the quality and safety of the care provided by the older people’s mental health inpatient units carried out by nurses and doctors from older people’s mental health units; second: a similar executive walk around audit carried out by members of the trust executive and non-executive directors and, third: the audit of
medical records of deceased patients on older people’s mental health wards carried out by the trust medical director.

The trust has a Care Programme Approach (CPA) policy. The latest version was implemented in October 2008. This replaced the February 2006 policy. The last audit of the CPA took place in March 2007, and we note to date that the latest CPA policy has not been audited.

A trust manager told us that he had identified eight clinical risks from serious untoward incidents reported in 2008/09. However we did not see evidence that any of these risks had been translated into audits of practice aimed at mitigating those risks. We were shown an audit programme for 2009/2010 that related to NICE guidance.

The overall impression we gained of the trust’s audit function was that it is not comprehensive. We were told that at the time of writing no member of the trust audit team had been invited to attend the older people’s mental health management group and there appeared to be little link between the trust audit function and the trust’s clinical governance structures.

It was reported that responses to requests for information to be used in audits tended to be low. In conjunction with this there appeared to be local audits that were being carried out without the central trust audit team’s knowledge. The trust has recently increased its central audit team to co-ordinate a more trust wide approach to audit but we were told that they were struggling to move forward to follow national guidelines against an emphasis on locality audit.

**Executive walk around audits**

Following the raising of issues of concern at Harbourne the trust has initiated an on-going programme of executive “walk arounds”, conducted by board members, and peer review audits carried out by clinical and executive members of staff. These walk around audits are a useful tool in spotting day to day issues and keeping individual units aware of scrutiny and therefore less likely to allow poor practice. We noted that the walk-around audits were pre-planned and we would expect to see an element of unannounced visit built in for various times of the 24-hour cycle. This would enable peers and the executive to be fully assured in relation to the standards they were meant to be observing and auditing. We note that they are a useful way for senior managers and board members to be more visible in the trust.

**Audits of nursing quality**

We noted that audits of nursing quality were, at least at the beginning of the period of our enquiry quite intermittent from 2006 to 2008 though they did become more frequent in 2008/09. In 2006/07 there were trust wide audits into dignity and respect and nursing supervision. In 2007/08 there was an audit in North Devon into supervision. In 2008/09 there were audits as follows: a review of mental health nursing; audit of the productive ward in Rougemont and Franklyn Wards; a trust wide national audit of falls and bone health for older people; an essence of care re-audit trust wide and an older people’s mental health peer walk around rolling audit as a result of the concerns raised at Harbourne.

**Department of Health guidance: clinical governance and adult safeguarding**

In February 2010, the Department of Health published guidance entitled “Clinical Governance and Adult Safeguarding – An Integrated Process”. This highlights the importance of linking
clinical safeguarding to the multi-agency approach to safeguarding. It advocates the dealing with incidents as part of a wider safeguarding process involving all agencies rather than solely “in-house” through trust clinical governance systems. This guidance is available on the Department of Health website.
11. Pharmacy services and support, and clinical supervision of controlled drugs

Medicines management encompasses all aspects of the way medicines are procured, prescribed, administered and reviewed to optimise outcomes of patient care. Audits of inpatient wards have suggested 98% of care plans in mental health services involve medication\(^2\). Therefore, as medicines play a significant role in the care offered by mental health trusts, medicines management must be a priority for these trusts.

Controlled drugs are prescribed medicines usually used to treat severe pain, induce anaesthesia or treat drug dependence. They play an important role in treating a range of clinical conditions. Due to the potential for abuse these are subject to special legislative controls. Controlled drugs are those defined in the Misuse of Drugs Regulations (2001), with their appropriate use in health care supported by the Health Act 2006 and its subsequent regulations and guidance.

**Findings**

- The trust has made significant improvements to medicines management since the appointment of the associate director for medicines management in April 2008.
- The level and frequency of pharmacy services and monitoring remains variable, depending on location.
- The trust has failed to formally sign the service level agreements with neighbouring acute trusts for provision of medicines.
- The trust has yet to complete its final phase of implementation of pharmacy services and pharmacy support.

**History of the trust’s provision of pharmacy arrangements**

When the trust was formed in 2001 little consideration was given to the pharmacy arrangements. The trust did not directly employ a senior pharmacist until January 2004, three years after the trust formed. The post-holder covered the whole trust and had an extensive remit without appropriate resources or support. Consequently, the post-holder had a limited presence on the wards and within the multi-disciplinary teams. The post-holder admitted it was a struggle to set up a safe medicines management infrastructure in the trust.

The current chief executive explained that when he took up a substantive post in April 2005 it was evident that the medicines management arrangements needed strengthening. In 2005 the Healthcare Commission carried out a review of medicines management in 42 mental health trusts, including Devon Partnership NHS Trust. This highlighted various shortcomings in terms of operational capacity of pharmacy within the trust.

The “significant risks” highlighted by this review were presented at clinical cabinet in June 2006 and to the board in November 2006. In the medicines management & therapeutics

\(^2\) Healthcare Commission (June 2007) *Talking about medicines: The management of medicines in trusts providing mental health services.*
committee meeting of 19 January 2006 it had been stated that the trust were “under-resourced
to provide a basic clinical pharmacy service.” By January 2007, the executive team had
acknowledged medicines management as one of the four clinical governance priority areas.

On 24 January 2007, the trust board agreed a three-phase pharmacy structure to expand
service provision:

- **Phase 1:** Establish core structure – Two medicines management leads; strategic and
  clinical effectiveness, with administrative and analytical support.
- **Phase 2:** Provide clinical input to the regions – Network lead clinical pharmacist in
  each of the three regions.
- **Phase 3:** Build up pharmacy support with medicines management pharmacy
  technicians in each network. Also involves a pharmacist to lead on medicines
  management training for future development.

The first appointment as part of the recruitment action plan was the strategic lead, the associate
director medicines management, who started on 1 April 2008. This was 16 months after the
board agreement. The associate director is also the trust’s accountable officer for controlled
drugs.

In phase 2, network lead clinical pharmacists were appointed to cover south Devon in January
2009 (1.0 full-time equivalent) and Exeter, east and mid-Devon in April 2009 (0.8 FTE). Due to
local pharmacist recruitment difficulties for the equivalent post in north Devon the informal SLA
arrangements were strengthened and in practice since October 2009.

Phase 3 had been stalled between July and October 2009 for financial reasons. The trust has
informed us that Phase 3 is in the process of being implemented. However, as of November
2009 no appointments had been made in line with phase 3. It was noted that completion of
phase 3 would provide the basic core service and would not be the end of service development.

**Pharmacy service level agreements (SLAs)**

The trust does not have an in-house dispensary and, therefore, does not supply medicines to its
own units. The supply of medicines is through service level agreements (SLAs) with adjacent
acute hospital trusts. However we discovered that these were not formal service level
agreements. The trust has therefore been relying on informal arrangements for the provision of
medicines. We were not confident of the robustness of these arrangements.

Within these informal agreements there was a varying degree of pharmacy support to the
inpatient units. There was a clinical pharmacy element for two out of the three contracts.
However, for the agreement covering south Devon the SLA pharmacist post had been vacant for
a number of years. There was no provision for any operational pharmacy service within the
Exeter and east and mid-Devon SLA. This resulted in no clinical pharmacy support for these
areas of the trust.

The three informal agreements were with the following health care providers:

- North Devon Healthcare NHS Trust
- The Royal Devon and Exeter NHS Foundation Trust
- South Devon Healthcare NHS Foundation Trust.
The informal arrangements were described as historic block contract agreements based around pharmaceutical supply. No service specifications were formally laid out. It proved difficult to performance manage the provision. No advice was taken from an experienced senior pharmacist in relation to the appropriateness of these informal arrangements until the appointment of the associate director medicines management in April 2008.

In the agreement with North Devon Healthcare NHS Trust there is the provision of 0.2 FTE clinical pharmacist input. It was confirmed that there has not been a qualitative evaluation of whether the input has been delivered to the standard expected by the associate director medicines management. Historically, Abbotsvale unit only received the pharmacy reconciliation controlled drugs checks of the content of the controlled drugs cupboard without any clinical pharmacy input. It was agreed that the SLA pharmacist will visit the unit once a week from 1 October 2009.

On an unannounced visit to the David Barlow unit at Barnstaple our investigation team found that there was no evidence to demonstrate that patients’ drug charts (drug prescription and administration charts) were clinically screened by the SLA pharmacist. We found no evidence of the pharmacist having signed to demonstrate that this had taken place. We raised this immediately with the trust and were told that this would be rectified. The trust subsequently introduced core pharmacy standards in November 2009.

In relation to the agreement with Royal Devon and Exeter NHS Foundation Trust, there was no clinical pharmacy support to older people’s mental health units across the region prior to April 2009.

In the agreement with South Devon Healthcare NHS Foundation Trust we found the acute trust was contracted to provide a specialist mental health pharmacist. However this post had been vacant for around two years and as a result Devon Partnership Trust had not received any clinical pharmacy support from South Devon Healthcare.

As of November 2009, draft formal SLAs with each of the three acute trusts were awaiting contractual agreement and signing. We were told that these draft SLAs now include performance measures. However North Devon Healthcare NHS Trust has highlighted that the draft SLA does not include any performance standards.

**Medicines management governance**

The trust has a responsibility to ensure quality and comprehensive management of medicines, including controlled drugs, is an integral part of its clinical governance process.

The Health Act (2006) sets out that all NHS trusts must appoint a senior manager as an accountable officer for controlled drugs. This post is responsible for the safe management and use of controlled drugs within the organisation, which includes ensuring the provision of appropriate training, monitoring and auditing the governance systems, and investigating concerns and incidents, that relate to controlled drugs.

Some members of staff we interviewed were not aware of the role of the accountable officer. As part of the role the board should receive regular controlled drug reports. Members of the trust
The board did not recall receiving regular reports from the accountable officer. The chief executive explained that the board relied on exception rather than routine reporting.

For medicines management the trust use the combination of a high-level policy supported in practice by standard operating procedures (SOPs). The trust is required to have SOPs in place to cover all activities related to controlled drugs. The trust introduced 17 SOPs in September 2008.

A majority of frontline staff we interviewed did not know of the current controlled drugs policy. Despite the policy and the SOPs being accessible on the intranet a review in early 2009 led by Devon PCT criticised that SOPs were not available to staff. As an example, during a visit to St. John’s Court in February 2009, we found that staff did not know that SOPs had been published five months earlier. In October 2009, the accountable officer did not think these were prominent on the units despite being introduced a year previously. The trust subsequently told us that they had set up a ward based medicines management link practitioner role and network in order to strengthen links and engagement with front line staff.

Medicines management audit

Audit provides a valuable mechanism for checking that current trust practices are clinically effective or that medicines management policies and procedures are being complied with. Due to the lack of clinical pharmacists until early 2009 regular checks of the units or trust-wide audits by pharmacy staff did not occur. On the October 2006 assurance framework it was noted that there was insufficient audit of current prescribing for active monitoring of safe and secure medicines management.

The accountable officer admitted in interview that due to current limited capacity and the time it would take to establish the operational roles of the recently appointed clinical pharmacists she has at present only “scratched the surface “regarding audit. The only medicines management projects in the trust’s audit program are those linked to NICE guidance. Some clinical staff did not think there were any formal audits regarding medicines management. Moreover, two of the network lead clinical pharmacists confirmed they were not being asked to complete audits.

In response to the incident at Harbourne all older people’s mental health units were audited with a specific focus on medicines management, especially regarding the use of opioids. Across the units some recurring themes were identified: use of anti-psychotics in dementia patients, use of two types of benzodiazepines at once, overuse of PRN medication, and concerns about whether appropriate checks were completed for physical medication.

Meetings

The primary medicines management committee was the medicines management & therapeutics committee (also referred to as the drugs & therapeutics committee, and later the medicines management group). This was chaired by the medical director.

Senior pharmacy staff summarised that everything regarding medicines management came through this committee. Due to the large remit of the committee it had a large agenda that lacked clinical focus leading to the clinicians to become disengaged from the committee. It was thought that clinicians did not prioritise the group and consequently attendance was poor. In half of the copies of minutes we received from the trust we found there were ten or more members of the committee not in attendance. There were also long periods of time between
meetings especially during 2006 and 2007. We understand that the meetings would not take place in the absence of the sole trust senior pharmacist, which further limited the effectiveness of the group.

Following a review by the associate director for medicines management, the committee was deemed ineffective and not performing the function it should. After consultation within the trust and discussions with Devon PCT (who had representation on the committee) it was disbanded following the last meeting in August 2009. In its place two groups were formed, split into clinical and business functions; a prescribing forum, and a medicines governance group.

Issues regarding medicines management that regularly appeared in minutes of the trust board meetings were about finance and Standards for Better Health core standard compliance, although the board received some occasional reports from the clinical cabinet, and the quality & safety committee that included pharmacy issues.

Risk

The trust’s corporate risk register lists medicines management as a significant risk from quarter 4 of the 2005/06 financial year (January – March 2005). The risk level rating was later reduced due to the planned restructuring of pharmacy and the appointment of the associate director medicines management. Evidence from staff interviews confirms that medicines management has been a long-standing item on the risk register and rated as one of the trust’s highest risks.

Incident reporting

All reported incidents that relate to medicines management are copied directly to the pharmacy team. This reporting arrangement was only initiated when the associate director medicines management joined the trust in April 2008. Since April 2009, one of the network lead clinical pharmacists has been the lead for pharmacy incidents.

There appears to be a low level of reported incidents in older people’s mental health relating to medicines management. In January 2006, the medicines management & therapeutics committee expressed concern that there appeared to be “significant under reporting of medication errors and near misses throughout the trust.” A Devon PCT led review in early 2009 commented that all members of staff were able to describe how they would report a controlled drug error. The pharmacists reported that the most common incident is the misidentification of patients (i.e. giving one patient another patients’ medication). We were assured the trust had acted to address this problem.

Example of a controlled drugs concern

On an unannounced visit to Franklyn hospital in October 2009 we found the unit’s controlled drugs cupboard contained a bottle of paint stripper placed on its side, a patient’s house keys, and money belonging to a patient who had since been discharged. It was explained that these items were being stored in the controlled drugs cupboard as there was limited access to the ward safe. The controlled drugs cupboard should only be used for storage of controlled drugs.

Finance

The director of finance described a high spend in the trust on medications and the associate director medicines management acknowledged an overspend against the budget. Pharmacy has
an annual budget of £2 million but data on total medicine spend supplied by the trust shows an average spend over the last six years of £2.56 million. Historic reasons were noted as an explanation for the overspend including contractual issues with the trust taking on primary care prescribing amounting to approximately £300,000. Savings have since been identified following discussions with prescribers.

**Staffing**

Since April 2009, the three main localities of the trust have had dedicated pharmacy support, however there are obvious differences between the three. This results in variable provision of pharmaceutical expertise.

Despite it being the region with the most inpatient units, the network lead clinical pharmacist in Exeter, east and mid-Devon can only attend each ward once a month. This has been criticised as too low an attendance to achieve the necessary level of pharmacy input at ward level. In contrast the clinical pharmacist for the southern area of the trust is able to attend each ward weekly. Prior to October 2009, Abbotsvale unit had no contracted clinical pharmacy cover.

It was obvious during staff interviews that the development of medicines management and the appointment of pharmacists have been positively received by the clinical teams. The appointment of the associate director medicines management is regarded as a significant milestone in the trust’s development of the medicines management service and has provided the trust with a clearer strategic direction.

**Training**

Throughout the interviews with clinical staff it became apparent that there was previously no specific medicines management training for nursing staff in the trust. Members of staff mentioned the need for training in the use and administration of drugs, and some staff were concerned regarding the lack of provision. It was unclear what level of training is available to medical staff. The associate director medicines management was not confident the level of training is appropriate. This had been highlighted as a risk.

It is intended to roll-out medicines management e-learning. The accountable officer wants the controlled drugs e-learning module to be part of the trust’s essential training for all medical and nursing staff within the trust. The controlled drugs e-learning was due to be launched in October 2009. Administration and prescribing modules were planned for November 2009.

**Community mental health teams**

There is no existing formal provision of clinical pharmacy service to the community teams. Further development of the pharmacy service will look to provide clinical pharmacy input in the community teams. Ideally, the trust would like to recruit a clinical pharmacist to work with the community teams in each of the three trust localities.
The accountable officer explained that the trust routinely monitors the use of opioids in older people’s mental health units. There was some use of opioids across the units in the trust although this lessened dramatically since guidance was issued in accordance with the PCT’s safeguarding process in March 2009. The guidance explained that opioids delivered by a patch or via a syringe driver should rarely be used within older people’s mental health and that Devon Partnership NHS Trust staff may not have sufficient skills to safely prescribe and administer these drugs.

**Syringe drivers**

A syringe driver is a portable battery-driver infusion pump used to give medication subcutaneously via a syringe. It allows continuous delivery to aid patient comfort whilst bypassing problems of dysphagia, weakness, or inability to take oral medication. It is not clear the trust had a structured approach, such as that recommended within the British National Formulary, for the use of syringe driven opioids for palliative care.

There is no trust policy in the use syringe drivers, and the trust has never had one. The associate director medicines management commented that the fact there was not a policy for syringe drivers should indicate that it is not within their scope of practice and members of staff were not expected to use them. Furthermore, there were no competency frameworks or training for syringe drivers.

The medical director expressed surprise that syringe drivers were being used at all in an older people’s mental health setting. This view has been echoed by other senior staff in the trust. Interviews with ward staff have confirmed that in all units except Harbourne, nurses would not be involved in the use of syringe drivers unless supervised by and with the involvement of palliative care teams. It was thought of as “unusual” that nurses on Harbourne were involved. The majority of ward staff felt the use of a syringe driver on older people’s mental health units was inappropriate or unnecessary. This is a marked contrast to views from staff based at Harbourne where the use of syringe drivers was referred to as “very beneficial” or “perfectly legitimate”.

The trust had been alerted to the potential risks associated with the use of syringe drivers prior to the allegations on Harbourne. On 17 July 2008, the medicines management group referred to NPSA guidance (2008/RRR05) on reducing dosing errors with opioid medicines with a focus on the use of opioids for pain relief and palliative care. It was highlighted that the forensic services occasionally provide palliative care even though this was not an area of prescribing their staff were familiar with. It was therefore noted that extra caution was therefore needed due to this not being an area of familiarity. This is reflective of practice on the Harbourne unit.

**Case note review – Syringe drivers**

From the 68 sets of patient notes reviewed as part of the investigation there were ten instances in which a syringe driver was used, with one more prescribed but not used. Eight of these were

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3 For the purpose of this report the terms opioid and opiate are considered largely synonymous, with opioid being used as it has a broader definition. An opioid is a natural derivative of opium, a semi-synthetic or a synthetic substance often prescribed to manage and control pain. Examples of opioid analgesics include diamorphine and fentanyl.
on Harbourne. Significantly, in five cases clear clinical need for a syringe driver was not demonstrated. Four of these were at Harbourne and one case was at St John’s Court.

**Opioid transdermal patches**

An opioid transdermal patch is where a painkiller slowly passes from a patch placed on the skin into the body to reduce the feeling of pain. These are used to treat severe pain and mainly used for patients who cannot receive oral medication.

Occasional use of fentanyl patches was described by ward staff on the majority of older people’s mental health units.

At Harbourne it was reported that some patients went straight to being prescribed an opioid patch ahead of other analgesics and therefore the analgesic pain ladder was not followed. One occasion was noted where the consultant prescribed a patch for a patient who did not appear to be in any significant pain.

In September 2009, the associate director (accountable officer for controlled drugs) informed us that Franklyn hospital (Rougemont and Westleigh) was a significant outlier for use of fentanyl patches. Again, some patients seemed to be prescribed a fentanyl patch without the analgesic pain ladder being followed. When the consultants were questioned regarding their prescribing they felt the patient population justified their decision.

**Case note review – opioid patches**

From the 68 sets of patient notes reviewed as part of the investigation there were 21 in which an opioid patch was used. There were 6 cases where it was not clear to the reviewer why a patch had been prescribed as there was no record that the patient was in pain.

**PRN medication**

Over-use of PRN (pro re nata or “as required”) medications was reported during staff interviews on two older people’s mental health units. As part of our case note review there were a few instances where multiple use of PRN medication should have been reviewed and changed to a regular daily dose, for example one patient received over 150 doses of lorazepam PRN rather the patient being reviewed and regular medication prescribed.

**Covert administration**

During a case note review of patients from Brunel lodge a patient was found to have had lorazepam covertly administered in a drink however there was not a supplementary care plan to support this action. This was raised with the nurse in charge of the ward at the time who agreed this needed to be addressed immediately. This action was in breach of the Nursing and Midwifery code of conduct. In October 2009, during an unannounced visit to Franklyn hospital the investigation team looked at a set of case notes and again found a supplementary care plan for the covert administration of medication was not used. From the documentation there did not appear to be any information demonstrating that advice had been sought from a clinical pharmacist regarding the covert administration.
Drug prescription and administration charts

It was a common observation that there are a variety of drug prescription and administration charts (drug charts) in use throughout the trust, some bearing the names of other NHS trusts. This may be indicative of poor governance arrangements. In a medicines management & therapeutics meeting in October 2005 the importance of producing a standardised chart for use throughout the trust was stressed by the trust pharmacist. Clinical cabinet again prioritised a single standardised chart in December 2006. A medicines management group meeting on 22 March 2007 identified the variety of charts as a possible risk that could contribute to prescribing or administration errors. An older people’s mental health peer audit review in January 2009 again raised the issue of different drug charts. During interviews in September 2009, we were informed that a standardised drugs chart was being completed. This suggests delayed action by the trust.

The Harbourne unit

Syringe drivers were being used to reduce agitation and control agitated dementia in what was referred to as a “drug regime”. Often patients would be prescribed a fentanyl patch and subsequently be placed on a syringe driver.

The medical director believed that the issues on Harbourne would have been picked up earlier had there been a pharmacist regularly visiting the unit.

The accountable officer of controlled drugs noted Harbourne had a lot of controlled drugs in stock, including diamorphine and midazolam. Staff from the unit reported the controlled drugs record book was not checked by a pharmacist as part of a regular pharmacy controlled drugs reconciliation checks.

In addition to the controls from January 2009 a clinical pharmacist conducted what were at first daily visits to the unit as part of the safeguarding process. This included a daily audit of medicines management.

The consultant appointed to Harbourne after the incident perceived that previously on the unit opioids were used to address distress and suffering rather than asking questions about what was causing the behaviour. He commented that he felt that this was cultural. It was noted that the unit was caring for a large number of patients with challenging behaviour and the increase in the use of syringe drivers was reflective of increasing severity of admissions. This did not remove the need to explore alternative therapies before resorting to the use of syringe drivers or opioid patches.

We would expect the trust to have a policy for the use of syringe drivers and for that policy to state clearly the level of training needed for a doctor or nurse to be able to use one. We would also expect to see a clear description of the circumstances under which a syringe driver would be employed. We note that no such policy existed.

The staff at Harbourne did not have specific training for using a syringe driver. A senior nurse explained that the qualified nurses calibrated the syringe driver even though they had only been shown how to do it once before and were not fully confident in their understanding.
Conclusion

From our observations, interviews and examination of trust evidence we conclude that the trust board may not fully appreciate the importance of medicines management, including controlled drugs in the operation of the trust’s patient services.

Pharmacy cover remains variable throughout the trust. It is disappointing that at the time of writing of the report the signing of the formal service level agreements for the provision of medicines was delayed.

At a senior level, medicines management issues were deflected to the associate director of medicines management with limited discussion at board level. The trust has made undoubted improvements in its pharmacy provision since April 2008. However, we are not yet assured that it has a fully effective and comprehensive medicines management and governance structure for controlled drugs.

We note that when the concerns were first raised at Harbourne the trust did not include the associate director medicines management in the initial serious incident review. The serious incident review did not refer to medicines management in any context other than the use of syringe drivers.

An effective technical and clinical pharmacy service could have recognised sooner the potential risk of the practices at Harbourne.
12. Trust’s plans for improvement

Findings

- The trust acted responsibly and promptly to the raising of concerns and has taken on board concerns that we raised with them as our enquiry progressed.
- The trust has shown itself committed to the financial investment needed to ensure that these improvements take place, although many of these have yet to be fully developed and achieved.

The trust has been open and shown a willingness to embark on an improvement programme for its older people’s mental health service. It has not waited until the end of the enquiry before starting this improvement process. During the course of the enquiry, the trust gave the investigation team a comprehensive outline of their overall improvement plan and we have invited the trust to keep us updated with their detailed plans.

The following principles are to be applied to the redesign:

- Larger more centralised inpatient units located in and covering the area previously covered by approximately three former smaller units.
- Single function units i.e. housing either organic or functional patients but not both.
- Dedicated consultants.
- Uniform admission, assessment and care criteria across the trust.

The trust is planning to develop clinical directorates with the aim of bringing clinicians and management together. The four directorates will be adult services, older people’s services, secure services and specialist services. This will involve unit delivery teams determined by geography. Each delivery unit will be responsible for the management of services in an area across the clinical directorates.

The trust has explained to us that the redevelopment of its older people’s mental health units will entail a capital cost of £4.8 million. A total of £3.2 million is required to bring the units up to an acceptable standard, which will include single rooms with en suite, single-sex accommodation, adequate space, access to appropriate outside garden areas.

The implementation of the improvement plan is overseen by a task group chaired by the Director of Business Development. The task group has established three sub-groups:

- Service design: The OPMH Professional Expert Group chaired by the Medical Director
- Quality and safety: Chaired by the Director of Nursing and Practice
- Operational implementation: General Manager for older adult services.

The progress of the improvement plan is summarised below in two sections. Each section represents a range of work streams.

Section 1: Investing in mental health services for older people:

- Service design
- Improving community services
• Improving inpatient services
• Strengthening integrated pathways

Section 2: The quality and safety of care:
• Clinical standards
• Clinical governance
• Safety improvement
• Workforce planning, training, development and supervision.
• Medicines management

Investing in mental health services for older people

Service design – model of care
The OPMH Professional Expert Group has designed a model of care to meet the needs of older people with mental health problems in Devon and Torbay. The model of care has been developed in consultation with the trust’s partner agencies – notably NHS Devon, Devon County Council and Torbay Care Trust – and is also informed by a number of different sources of feedback from the people who use services.

The trust has stated that it needs to continue increasing the range and depth of community services and further reduce the level of dependency on inpatient services. At present, 70% of the trust’s resources are focused on inpatient services, which are only ever used by approximately 8% of older people requiring care and support. Only 30% of resources are invested in community services, which are needed by the vast majority of older people – approximately 92%, according to trust estimates.

The trust states that its plan for improving services for older people with a functional illness is to enable them to access all of the support, care and treatment that is available to younger adults, thus establishing services that are based on need, not age. However, the trust recognises that some people with functional mental health problems combined with needs related to older age will require specialist assessment, care and support. The trust has said that this will be provided by specialist older people’s mental health teams and will include:

• Mental wellbeing and access services to help people stay well
• Recovery and independent living services for people with long-term conditions
• Crisis resolution and home treatment services
• Day treatment
• Hospital care.

Services for people with dementia will provide:
• Early diagnosis and intervention service, including memory services (EDI)
• The management of psychological symptoms and challenging behaviour (including crisis resolution and home treatment services)
• Training, education and support for carers
• Dedicated liaison with other parts of the health and social care network and signposting to other services
• Hospital care.
In December 2009, the trust Board of Directors approved the business case for the capital and revenue investment in community and inpatient services required to transform services for older people in Devon and Torbay.

The delivery of the National Dementia Strategy will require additional investment across the whole health and social care community. The trust has put proposals for the delivery of memory services (EDI) and acute medical hospital liaison services to its commissioners and these will be the subject of forthcoming contractual discussions.

**Community mental health services**
The OPMH Professional Expert Group has specified the skills mix and establishment of the multidisciplinary community teams based on population size, predicted morbidity and the capacity with the aim of redressing previous inequalities of provision. The trust says that this will require significant investment with some areas such as north Devon.

The trust states that the improvements to community services will be phased. Crisis resolution and home treatment services have been identified as the first priority and the trust states these will be in place by June 2010. It states that other community services will be fully in place by March 2011 when the last of the refurbished inpatient units reopen.

The trust intends that community teams will provide a range of specialist services to people with both functional and organic mental health problems but will operate as integrated and co-located teams.

The community teams will be based in a network of community resource centres across the county. These will essentially be local centres for older people’s mental health services where the trust intends to provide wide range of services on-site, as well as specialist support and liaison services into every local community in Devon.

**Inpatient services**
The trust has said that it is committed to less reliance on hospital services. However, it is equally committed to ensuring that there will always be hospital beds for the relatively small number of people who need them and to improving levels of quality, safety, privacy and dignity on its wards for older people. This will involve renovation of wards to provide an environment that ensures privacy and dignity and the separation of wards for people with dementia and those with a functional illness.

The trust has confirmed plans to invest £3.8 million to improve inpatient services in Barnstaple, Exeter and Torbay.

The trust has produced a schedule for refurbishment has been outlined by the trust, which will be phased across North Devon, Exeter, East and Mid Devon and South and West Devon.

**Strengthening integrated pathways**

**Revised admission criteria**
The trust has advised that it will continue to work with partner agencies to reduce the number of admissions (concentrating on only those patients who cannot be managed in any other setting) and delayed transfers of care. Revised admission criteria and a protocol for delayed transfers of care have been drafted and are being piloted in Exeter.
Workforce planning
The trust has said that the skills mix and overall staffing levels on some units has become insufficient for the level of dependency of the patients. Particular problems have included low levels of qualified nurses on some units and a reliance on NHSP (bank) staff. The trust has stated that use of agency staff now requires executive authorisation.

The Director of Planning has worked with ward managers and modern matrons to design a standard ward rota for nursing and nursing support staff with the appropriate skills mix and establishment. The trust says that these rotas take account of ward size and function (i.e. caring for people with functional or organic mental health needs). A dependency analysis was commissioned from Dr Keith Hurst, Senior Lecturer at the University of Leeds (August 2009). The trust states that this analysis recommended nursing establishments slightly below those currently being implemented.

The trust’s stated immediate priority has been to address the nursing levels on inpatient wards. The implementation of a standard ward rota began in August 2009 but has been complicated by uncertainty about the final configuration of inpatient services and also the HR implications of appointing redeployed staff to substantive posts from suspended services that are geographically dispersed. It has not been possible to recruit to substantive posts in those wards scheduled to be suspended for refurbishment but staffing has been improved by the voluntary increase in hours of some part time staff and also the block booking of NHSP staff who have previously worked regularly on particular wards.

Following refurbishment, the trust states that all wards will reopen with full nursing and associated health professional staffing establishments.

The trust states that, following the work undertaken with an external expert to assess staffing needs, it’s current older people’s mental health inpatient staffing levels are in the top 10% of trusts according to the Audit Commission’s benchmarking exercise in October 2009. The same benchmarking exercise places the trust in the bottom 41% of trusts for the number of staff in older adult integrated community mental health teams per thousand population and the bottom 33% for the number of community mental health team nurses per thousand population. This is based on data provided to the Audit Commission by the trust.

The implementation of the standard ward rota will be supported by the introduction of electronic rostering scheduled for April 2010.

The productive ward has been piloted at Franklyn Hospital with the aim of releasing clinical staff time for the delivery of direct care. The evaluation of this will be completed in May 2010 and consideration given to implementing the programme on other inpatient wards.

The Productive Mental Health Ward is supported by eight modules and they have three Foundation models. These involve looking at the environment and housekeeping of the ward, knowing about the practice of the ward, focusing on ward rounds, and a module on wellbeing.

The Medical Director has reviewed and redrafted the service level agreement for medical screening and emergency medical response and the trust is currently seeking a response from the host providers to these changes.
The local arrangements for referral to dieticians, speech therapists, physiotherapy, continence services and palliative care have been clarified between the trust and the relevant provider (primarily Devon Provider Services).

The trust says it has identified the functions to be delivered within community and crisis resolution and home treatment services together with the skills mix and staffing establishments required to deliver them. Some elements of community services are not currently provided by the trust in all areas (eg early diagnosis and intervention) and are the subject of discussions with the trust’s commissioners.

With the exception of these un-commissioned services, the board has formally approved the case for investment to deliver the improved services. This includes the provision for medical staffing and allied health professionals such as occupational therapists and psychologists.

The quality and safety of care

Clinical standards
The Director of Nursing and modern matrons have worked with ward managers and the OPMH Professional Expert Group (PEG) to define the inpatient care pathway and the standards of clinical practice to be applied to this. The components of the pathway are:

- Referral and admission
- Two-hour and 72-hour assessments on admission
- Personalised and outcome focused assessment (including mental capacity and consent)
- The planning of care, treatment and support
- The identification of the range of interventions that should be available to each person (informed by NICE guidelines, evidence based best practice and PBR clusters)
- The delivery of care, treatment and support
- Review and evaluation
- Discharge planning
- Discharge and post discharge activities.

The standards are based on the trust-wide clinical quality standards set by the Clinical Cabinet in November 2009 and describe:

- The service each person using the service and their families can expect to experience at each stage of the pathway.
- The information that should be available to people who use services, their families and other supporters.
- The activities and practice that will deliver each component of the pathway.
- The standardised tools and documentation that will be used for each component (eg standard and older people’s mental health specific assessment and care planning tools and recording and communication templates).

The trust says that this work will be completed by early 2010. The full suite of clinical records, guidance and tools will be implemented across all units in February 2010. The Director of Nursing is working with the RiO implementation team to ensure that the single electronic care record will support these processes and the audit of standards when it is phased in from June 2010.

In the interim, the audit of standards will be reliant on the use of the trust’s Practice Quality Audit Tool (PQA). This is a supervision tool that is applied to a centrally generated sample of
records. The data from PQA is collated by the clinical audit team. This will be reported through
the clinical effectiveness group to the quality and safety committee and the Board. The first
PQA report is due in March 2010

The care pathway and associated standards for community services and crisis resolution and
home treatment have been redesigned.

The trust states that, although the work described above is not complete, some essential
processes within the inpatient care pathway have been prioritised and addressed:

Clinical records
Revised documentation is in place (but still with some local variation) for:

- Assessment plans for the period immediately following admission. Assessment
templates are now in place for use at two hours and during the first 72 hours of
admission (including risk assessment and management plans).
- Assessment and care planning guidelines for physical health needs including
nutrition, hydration, mobility and tissue viability.
- Resuscitation status forms.
- Mental capacity, consent and best interest recorded for all aspects of care and
intervention.
- Information for people who use services, their families and other supporters.

Quality standards for record keeping
The trust advises that its safety lead has used safety improvement methodology to test and
spread standards for record keeping, which include factual accuracy, appropriate content,
legibility, dating and signing as well as the organisation of information in the clinical record. It
states that the spread of these standards across older people’s mental health inpatient units is
largely complete and will be achieved in all inpatient units (including adult services) by May
2010.

End of life care
The trust states that an end of life policy was implemented in November 2009. The policy was
written in conjunction with palliative care services and a formal agreement is now in place with
these services for the setup, supervision and changing of syringe drivers for pain relief –
although this is still expected to be a rare event in DPT inpatient units

The storage of medication
Following concerns raised by Care Quality Commission investigation team about the storage of
medication and the cleanliness/organisation of treatment rooms on some wards, a standard
schedule of daily, weekly and monthly ward checks for all treatment rooms and equipment has
been implemented (December 2009).

Clinical governance
The trust states that clinical directorates will be introduced by April 2010 aimed at creating a
clear line of clinical accountability from the level of the individual practitioner, through clinical
team leaders, to clinical directors and the Board.

The trust has clarified clinical governance as follows:
• The terms of reference, membership and chairing of the Quality and Safety Committee have been revised (October 2009). From January 2010, the committee will be chaired by the Medical Director and will report directly to the Board of Directors.

• A Clinical Effectiveness Group was established in June 2009 to replace the clinical cabinet in overseeing the clinical audit programme and ensuring that audit is translated into action plans for improvement. The Clinical Effectiveness Group is chaired by the Medical Director and reports to the Quality and Safety Committee.

• The reporting and accountability lines of the clinical executive, clinical cabinet and subsidiary professional committees have been revised (October 2009). The function of clinical cabinet will be further reviewed in January 2010 in preparation for the introduction of clinical directorates.

• The trust advises that senior clinical involvement in the review and investigation of serious untoward incidents has been strengthened. Since July 2009 clinical membership of the serious untoward incident group has included the Director of Nursing and Practice, a consultant psychiatrist and the nurse consultant (acute care).

• The trust states that deaths of people who are in contact with trust services are reviewed at the fortnightly serious untoward incident review group, which instigates further investigation where indicated.

Safety improvement
The trust has seconded the deputy director of care to the role of trust safety lead with responsibility for safety improvement across all services. This role has been confirmed as a trust-wide support function for the clinical directorates from April 2010. The safety lead is supported by senior clinicians, managers and executive directors who have completed accredited patient safety training. The key functions of the safety improvement plan are:

• To develop a safety culture throughout the organisation.
• To improve systems for the reporting, analysis and learning from adverse incidents, including regular safety bulletins.
• To develop safety awareness and leadership at the team level through training.
• To support local improvement projects.

The trust states that the work of the trust safety team has already had a considerable impact within the older adult acute inpatient wards. The improvements described above have been achieved through Plan Do Study Act cycles (PDSA), which have engaged ward staff and raised the profile of safety in clinical settings. This has been supported by electronic safety bulletins that spread learning and good practice.

The trust is one of four Mental Health trusts selected to pilot new patient safety processes through the Health Foundation’s ‘Improving Safety in Mental Health’ Programme. This pilot comprises three work streams within older people’s mental health services: developing leadership and staff commitment to improving safety; medicines management and the communication of clinical information. As part of the Health Foundation programme, a series of training events will take place in January 2010. These will include safety awareness raising for all staff and the training of a safety link worker for each team.
The training, development and supervision of staff and workforce planning.
The trust has said that it recognises the delivery of supervision and appraisal (PDR) has been inconsistent with particular problems in some of the older people’s mental health inpatient wards.

The delivery of effective supervision and appraisal has been identified as a trust priority. A detailed plan is in place to ensure full implementation of the supervision and appraisal policy by March 2010 and achieve compliance with Standards for Better Health standard C5b.

The trust says that it recognises that the most significant obstacle to delivering supervision on older people’s mental health inpatient units has been the level of staffing and the skills mix of teams. This is being addressed by the introduction of standard ward rotas.

A particular concern has been the supervision available to ward managers; this has been partially addressed by the appointment of additional modern matrons, although the full complement is yet to be appointed. The trust states that all ward managers now receive supervision and have scheduled appraisal reviews.

The arrangements for medical supervision and appraisal are included within the work described above although final guidance on the revalidation process is still awaited.

The trust acknowledges that its own reviews have identified deficiencies in the knowledge and skills of staff in some older people’s mental health inpatient teams. This was mirrored by our own findings. The trust states that they are being addressed as follows:

Modular training programme
As a result of issues that arose from the investigation into concerns at Harbourne, an in-house training course for nurses working in specialist older people’s mental health inpatient services has been developed. The course runs over five half day sessions and covers the topics of:

- The code of practice for nurses and midwives
- Assessment and care planning
- Medicines in older age
- Mental capacity, consent and deprivation of liberty
- Recovery, personhood and person centred care.

This course has been delivered twice in July/August and September/October 2009.

The management of challenging behaviour in dementia
The trust has recognised that better training in the management of challenging behaviour in dementia is required. The Medical Director is working with the OPMH PEG to review the best and evidence based practice and incorporate this into a care pathway for behavioural and psychological symptoms of dementia. This work will provide guidance on assessment and management with emphasis on education of carers, appropriate environment and activities and the appropriate use of medication and monitoring for side-effects. To support a greater understanding of caring for people with dementia, training is currently being devised and implemented at three levels:

- An e-learning module to raise awareness of the needs associated with dementia – for all staff working in older people’s mental health, adult and learning disability
services. This has been developed by Devon County Council and will be available from April 2010.

• The incorporation of an additional module into the older people’s mental health modular training programme referred to above.

• The trust currently runs a degree module in ‘capable practice in acute care’ in academic partnership with the University of Plymouth. The module is being redesigned to ensure that practice within older people’s mental health acute inpatient services is included. The next degree module was expected to start in January 2010.

Personalised and recovery focused care
The trust has said it recognises the need to strengthen professional leadership, particularly within nursing. It says that leadership will be further developed by the implementation of clinical directorates. Each directorate will include a professional lead that will be responsible for the standards of professional practice within the directorate but will also carry corporate responsibility for the leadership of their profession. The professional leads will report to the Director of Nursing and Practice.

Within nursing, professional leadership has been strengthened by the appointment of additional modern matrons in older people’s mental health services in South and West Devon (May 2009) and Exeter, East and Mid Devon (August 2009). An appropriate candidate is yet to be appointed to the North Devon post. This post will be re-advertised but additional professional support has been put in place by the secondment of a band 7 practice improvement lead. Further support is being provided by the modern matron for adult acute services in north Devon.

The intention is to foster a culture of leadership and accountability throughout nursing rather than a reliance on hierarchical structures. To support this, three Action Learning Sets have been created in collaboration with the University of Plymouth. A fourth ALS will begin in summer 2010, which will also be open to other professions.

Medicines management
The governance of medicines management has been strengthened by the establishment of responsible committees for each of the ‘design, do and check’ functions. The trust states that the Medicines Management Professional Expert Group now oversees the work of the Prescribing Forum and the Pharmacy Governance Group.

The trust states that Pharmacist attendance at multidisciplinary team meetings is now available on most wards and clinical pharmacy support is available at other times to all wards. Clinical pharmacy standards have been developed (October 2009) and a medicines information service is now available (June 2009). Weekly pharmacy visits to all older people’s mental health wards are now the standard requirement and the trust states that recruitment to the one unfilled pharmacist post will ensure this standard is met.

The trust states that service level agreements are in place for the provision of medicines from adjacent trusts. However the trust has not stated whether these have been formally agreed and signed. Additional requirements are now in place for controlled drugs: all controlled drug orders must be countersigned by a DPT Doctor before being dispensed.
Additional support has been developed to improve prescribing practice. The purpose of this is to promote an improved understanding of and adherence to national guidelines on best practice in prescribing. The support provided includes:

- An older people’s mental health consultant psychiatrist peer case based discussion group.
- The Prescribing Forum.
- A medicines management newsletter that is an insert to *Partnership Progress* (the trust’s in-house newsletter attached to staff payslips each month).
- Safety briefings and alerts.
- E-learning module for medicines reconciliation (part of the Health Foundation Improving Safety in Mental health programme). This has been completed by a large number of doctors and nurses.
- Standardised prescription sheets.
- Regular audit of prescription sheets.
- Electronic prescribing and administration guidance packs.

The trust states that an enhanced training programme for all clinical staff is now in place. In addition to bespoke taught sessions, the training programme includes mandatory induction and annual updates. E-learning modules and/or taught sessions are now available for:

- Controlled drugs
- Understanding side effects of medication and contra indications
- The use of as required medication
- Rapid tranquillisation (e-learning module delayed for technical reasons)
- Medicines reconciliation.

The role of medicines management link practitioner (MMLP) has been introduced. Each ward now has a practitioner to provide support for and maintain a focus on good practice and to act as a conduit for emerging guidance in medicines management. The first network MMLP event was held on the 21 October 2009.

The provision of information about medication for people who use services, their families and other supporters has been improved as follows:

- The trust website has an increased focus on ‘taking care of yourself’ and on improving choice in the use of medication.
- Clinical pharmacists regularly attend service user and carer forums to provide advice and answer questions.
- People who use services and their supporters are represented on all medicines management governance groups.
- A pharmacy-led ward ‘question and answer’ service is being piloted on one ward in Exeter.
13. Conclusions

We carried out an investigation in response to concerns that had been raised at the Harbourne mental health unit for older people, part of Devon Partnership NHS Trust.

As part of our enquiry, we also reviewed the care in the trust’s other mental health units for older people. We looked at the trust’s model of older people’s mental health care, focusing on patients’ referral, assessment and recovery, end of life care, and the culture within which these were delivered.

We examined the trust’s clinical governance arrangements to see how far they helped the board and managers to understand what standards of care were being delivered. We also looked at the trust’s medicines management and pharmacy services, particularly in relation to controlled drugs and the way they were prescribed, for example in cases of people with dementia.

The trust was open and honest in the way it reacted to the concerns that had been raised. It cooperated fully with its strategic health authority and partner agencies, both in the initial enquiry and in safeguarding the people using the services once the allegations became known. The trust has cooperated fully with us during the course of our enquiry.

Allegations of poor care at the Harbourne unit

At Harbourne, the doctors tended to work in isolation and without challenge to their approach to patient care from within the unit or the wider trust. There was a tendency towards administering opioids (medicines that help to manage and control pain) and to not adequately consider alternative responses to patients’ symptoms and distress. Although members of nursing staff tried to care for patients as best they could, there were examples of poor nursing care in an environment that was unsuitable for patients with dementia. The service at Harbourne was suspended in July 2009.

Standards of care at the other mental health units for older people

We did not find the same overall level of concerns in the other units. However, we did find differences across the units in care planning and in the way care was delivered, and indications that each unit was isolated in terms of its service management, practice development and record keeping. Standards of care improved as our enquiry progressed. However, there were still significant areas for improvement in care planning, physical health care, multi-disciplinary working and ward rounds.

The trust’s model of mental health care for older people

We found variations in assessment, care and treatment of patients across the trust’s different localities. The lack of a clear, shared vision for older people’s services compounded these differences. Due to an inadequate and incomplete management structure, ensuring consistency of care fell to local groups and structures, particularly at ward level. As our enquiry progressed,
the trust made significant advances in clarifying its vision and developing an action plan for modernising its services for older people.

Environment and facilities

The environments of the units were pleasant overall, with members of staff making the best use of facilities for the benefit of patients. However, the trust was unable to completely guarantee the dignity of patients by making single sex accommodation and separate bathroom facilities fully available. The trust has plans to address these issues as part of the redesign of its buildings and facilities for older people.

Staffing

While it implemented savings as part of the trust’s financial recovery plan, the board did not receive enough reports showing how the quality of care was being maintained and improved. Frontline care staff continued to say that not enough was being done to systematically address staffing numbers. The lack of clear managerial arrangements within the older people’s mental health service contributed to this.

The trust is now implementing a standard model for identifying staffing requirements.

Line management and supervision

A lack of clear and consistent line management, and of recorded and effective appraisal or peer review of consultants, helped to create an environment where the practices at Harbourne could take place unchallenged.

Nursing, in particular, lacked the leadership and presence of a substantive director of nursing, or a full network of modern matrons or clinical nurse leaders for a long period of time.

During the course of our enquiry, the trust improved its nursing leadership by appointing a substantive director of nursing and some of its complement of modern matrons.

Training

The trust had significantly improved its uptake of mandatory training for nursing staff working in older people’s mental health. It had relied heavily on e-learning, but beyond this there was a lack of professional and educational development for those nursing staff. This has led some staff lacking confidence in applying the Mental Health Act and Mental Capacity Act in their day-to-day care of patients.
Culture of the older people’s services and engagement with people, carers and families

The trust’s mental health units for older people are isolated from each other. We found differences in the extent to which each locality collaborated effectively with partnership agencies. The lack of crisis resolution teams and the reconfiguration of social care arrangements have affected both patient admissions and the speed of discharge of people from inpatient units.

We found that the level of community mental health workers varied depending on the location and did not increase enough to compensate for the reduction in inpatient beds. In particular, there was a shortage of community mental health workers in North Devon. We found evidence of involving carers and family members in decisions about people’s care at all the units we visited.

Clinical governance

We found local clinical governance arrangements that were well documented. However, there was confusion and misunderstanding at all levels of the trust in relation to trust-wide governance arrangements and clear accountabilities of its various committees, particularly in relation to the clinical cabinet.

The trust had found it difficult to establish a formal link between local and central arrangements. Clinical governance arrangements were not supported by an adequate, comprehensive, trust-wide audit strategy, or by activity being linked to risk or serious untoward incidents, for it to sufficiently monitor compliance with service and clinical standards.

During the course of our enquiry, the trust took remedial action to simplify and clarify its clinical governance structure and accountabilities.

Pharmacy services and support, and clinical supervision of controlled drugs

There was inadequate medicines management for a long period, which contributed to a lack of systematic provision, monitoring and reporting of pharmacy services. Had more robust arrangements been in place earlier, unusual or exceptional prescribing, such as at Harbourne, would likely have been identified and investigated at an earlier stage.

The trust has shown that it is committed to improving its pharmacy services with the appointment of an associate director/accountable officer for controlled drugs and the appointment of pharmacists to ensure adequate governance. It still has progress to make to embed these improvements.

The trust’s future plans

The trust has not waited for the publication of our report. It has proactively started a process to improve its mental health service for older people. This includes setting up a task force to redesign the service and putting in place a process to standardise assessment, care planning,
treatment, patient discharge and liaison with community mental health services and partner agencies.
14. Our recommendations

**Recommendation 1**

The trust board must have sufficient systems in place to be assured of safe and appropriate treatment and care of older people with mental illness in line with national strategies and guidance, both within its inpatient units and under the care of its community mental health teams.

**Recommendation 2**

The trust must ensure that it has an agreed model of care for its older people’s mental health service with standardised and appropriate crisis resolution, inpatient admission criteria, assessment criteria, care plans, care pathways and discharge criteria, and including clear definitions of types of care such as recovery, palliative care and end of life care with associated and specified treatment and care regimes.

**Recommendation 3**

The trust must carry through to completion a planned programme of older people’s mental health service redesign. This should take account of patient needs and dignity, including the separation of services for older people with organic mental illness from services for older people with functional mental illness. It should also comply with national government requirements for single-sex accommodation.

**Recommendation 4**

The trust must ensure that it has adequate and standardised numbers of medical and nursing staff at all of its inpatient units, as well as sufficient numbers of community mental health workers to reflect the greater emphasis on treatment in the community. It must also provide access for patients to sufficient numbers of allied health workers such as occupational therapists, dieticians, physiotherapists, psychologists, and speech and language therapists in order to provide effective treatment and care.

**Recommendation 5**

The trust must ensure greater effective joint working with partner agencies such as social services, the strategic health authority, and primary care care trusts to ensure that the optimum service is offered to service users within the trust’s geographic area.
Recommendation 6

The trust must make improvements to its leadership by ensuring that key posts are filled on a substantive basis, strengthening nurse and clinical leadership by ensuring that regular clinical supervision is carried out and recorded, and by ensuring that all clinical and non-clinical members of staff receive a full, recorded annual appraisal.

Recommendation 7

The trust must develop its training provision for nursing members of staff beyond the mandatory stage, and implement its planned training and development programme for all medical and non-medical members of staff using a variety of training media and environments. It must translate its planned training programme for all staff into actual training.

Recommendation 8

The trust must clarify its clinical governance arrangements, with clear accountabilities and links between local and corporate structures taking account of and linking risk, serious untoward incidents, audits and operational management accountabilities. It must ensure sufficient and timely reporting to ensure that the board has ongoing assurance in relation to the quality of patient services, patient safety and patient safeguarding in all localities.

Recommendation 9

The trust must ensure the completion of all stages of its pharmacy improvement programme, including the recruitment of remaining vacancies and the formal signing of its service level agreements for pharmacy services. It must ensure that sufficient reports are made available to the board to enable them to be assured that the organisation is fulfilling its role in relation to controlled drugs, and for the board to be assured that all policies regarding medicines management are being applied consistently across the trust.
Appendix A: Terms of reference for the investigation

The Care Quality Commission has received serious concerns about the quality of care provided by Devon Partnership NHS Trust to older patients requiring mental health care. Concerns have been raised in relation to recovery, palliative and end of life care, the provision of pharmacy services and the issue and use of controlled drugs, its governance arrangements and its management and clinical supervision arrangements particularly in relation to individual older persons’ mental health units.

The Care Quality Commission will therefore conduct an investigation to establish whether these concerns have foundation and what action might be required to improve services for older people requiring mental health care.

The investigation will include an examination of:

a) The allegations of poor care at the unit where the concerns were first raised and a review of standards of care at other similar units.

b) The adequacy of the trust’s model of service provision of care for older people requiring mental health care and in relation to referral, assessment, recovery, palliative or end of life care, including care pathways.

c) The culture of the trust’s older persons’ mental health service and the extent of engagement with service users, their carers and families.

d) The trust’s clinical governance, clinical supervision and management arrangements, including the arrangements at strategic and local level to assure the safety of patients and the quality of care.

e) The trust’s recent and present provision of pharmacy services, clinical pharmacy support, and the extent of clinical supervision in relation to the issue and prescribing of controlled drugs.

f) Any other matters which the Care Quality Commission considers arise out of, or are connected with, the above.

Additional information
The investigation will be conducted by the Care Quality Commission using the Care Quality Commission’s powers under Section 48 of the Health and Social Care Act 2008.

The Care Quality Commission has already been in discussion with the South West Strategic Health Authority and Devon and Cornwall Police and is satisfied that current multi-agency patient safeguarding arrangements are in place at the trust.

The Care Quality Commission will publish a report on the findings of the investigation and will make recommendations as appropriate to the trust and other relevant bodies.
Appendix B: Older people’s mental health services provided by the trust

North Devon

Bideford Hospital
- Abbotsvale Unit – a 12 bedded inpatient and day unit for the assessment of adults over 65 years with either functional or organic disorders.
- North Devon Community Mental Health Team – a community team providing a range of mental health services for people over 65 years in the North Devon area.

North Devon District Hospital
- David Barlow Unit – a 16 bedded inpatient unit for over 65s with organic and functional disorders.

Mid Devon
- Melrose Unit – a 12 bedded unit providing assessment and treatment for people over 65 years with primarily organic illness.
- Redvers Unit – an assessment inpatient unit for older people with mental health needs. (this unit was suspended in October 2008 as an inpatient unit; it currently provides social day services.
- Boniface unit – providing sessional day services including memory clinics.
- Mid Devon Community Mental Health Team – providing assessment and treatment in the community to people usually over the age of 65 in the Okehampton, Tiverton, Crediton and Cullompton areas.

Exeter

Franklyn Hospital
- Rougemont Ward – an 18 bedded ward for people over 65 years with a functional mental problem living in Exeter, East Devon and Mid Devon.
- Westleigh Ward – an 11 bedded acute assessment and treatment service for people over 65 years.
- Exeter Integrated Team (Exeter Older Adults Community Mental Health Team – provides community assessment and treatment to people usually over the age of 65 in the Exeter area.
East Devon
- Ottery St Mary Hospital – an NHS Devon and Devon County Council led day service for people usually over 65 years with either functional or organic illness.
- St John’s Court – a 14 bedded inpatient unit providing assessment and treatment to people usually over 65 years with organic illness.
- Stowford Lodge Day Centre – providing day services for people usually over 65.

Honiton Hospital
- The Bungalow – a 14 bedded inpatient unit and day care service. This was suspended as an inpatient unit in March 2009 and is due to re-open in April 2010 as an inpatient unit for the assessment of adults usually over 65 with functional illness.

South Hams and West Devon
- Community Mental Health Team – working with people who use services within the local community of Ivybridge and Totnes.

Totnes Hospital
- Harbourne Unit – an assessment and treatment unit for older people with functional and organic mental health problems. (The number of beds on this unit is officially 8 but at the time of the enquiry the number of patients was limited to 5.) This unit was suspended by the trust in July 2009.
- Totnes and District Older People’s Community Mental Health Team – providing community assessment and treatment of adults usually over 65 with both functional and organic illness.
- Rural Older People’s Mental Health Team – providing the same service in the areas of Tavistock and Ivybridge.

Plymouth
- 6 beds are commissioned from Plymouth PCT for older people in this area needing inpatient admission. 3 beds are in Oakdale unit for patients with functional illness and 3 are in Pinewood for patients with organic illness.

Teignbridge
- Brunel Lodge – a 16 bedded inpatient unit for the assessment of adults usually over 65 years with either organic or functional disorders.
- Community Mental Health Team covering the area of Newton Abbot.
- Templar House Day Hospital – provides sessional day services for people usually over 65 years with both functional and organic disorders.

Torbay
- Chadwell Day Hospital – a community based day treatment for older adults offering assessment and therapeutic group work.
- Community Mental Health Team covering the area of Paignton.

Torbay Hospital
- Fernworthy Unit – was a 16 bedded unit. This unit was suspended for refurbishment in December 2008.
Appendix C: The investigation team

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Investigation Manager
Care Quality Commission

Kathryn Hyde-Bales
Senior Investigations Analyst
Care Quality Commission

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Investigations Coordinator
Care Quality Commission

George Catford
Investigations Analyst
Care Quality Commission

James Mountain
Investigations Analyst
Care Quality Commission

Amber Sargent
Investigation Officer
Care Quality Commission

Rona Nicoll
Senior Legal Adviser
Care Quality Commission

Julie Meikle
Senior Manager
Mental Health Policy,
Regulation and Strategy
Care Quality Commission

Bob Jones
Mental Health Act Commissioner
Care Quality Commission

Iben Altman
Chief Pharmacist
South Downs Health NHS Trust

Dr Andy Barker
Consultant in Old Age Psychiatry
Hampshire Partnership NHS Foundation Trust
Richard Clibbens  
Nurse Consultant  
South West Yorkshire Partnership NHS Foundation Trust

Dr Norma Delany  
Consultant in Old Age Psychiatry  
Hampshire Partnership NHS Foundation Trust

Stephen Firn  
Chief Executive  
Oxleas NHS Foundation Trust
Appendix D: Interviews

The investigation team conducted a total of 229 interviews. Of these, 185 interviews involved 172 former or current trust staff (some people were interviewed more than once). Table 1 contains more details regarding the former and current staff interviewed.

The investigation team conducted 44 interviews with stakeholders (members of the public or members of statutory or voluntary organisations). Stakeholders were interviewed face to face or by telephone either as a result of contacting the investigation team or in response to an invitation from the investigation team. Tables 2 and 3 provide more details regarding the stakeholders involved in this investigation.

Table 1: Trust staff and former trust staff interviewed

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Chief executive and executives</td>
<td>17</td>
</tr>
<tr>
<td>Chairman and non-executive directors</td>
<td>6</td>
</tr>
<tr>
<td>Senior nurses and specialist nurses</td>
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</tr>
<tr>
<td>Nurses and health care assistants</td>
<td>61</td>
</tr>
<tr>
<td>Consultants (including clinical directors and heads of division)</td>
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</tr>
<tr>
<td>Junior and middle grade doctors</td>
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<tr>
<td>Senior and middle managers</td>
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<tr>
<td>Pharmacy staff, allied health professionals and chaplain</td>
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</tr>
<tr>
<td>Social workers</td>
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</tr>
<tr>
<td>Administrative and legal staff and analysts</td>
<td>2</td>
</tr>
<tr>
<td>Domestic and portering staff</td>
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<tr>
<td>Union representatives (trust staff)</td>
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</tr>
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<td><strong>Total</strong></td>
<td><strong>172</strong></td>
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Table 2: Stakeholders interviewed

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<tbody>
<tr>
<td>Patients and relatives</td>
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</tr>
<tr>
<td>South West Strategic Health Authority</td>
<td>2</td>
</tr>
<tr>
<td>Devon Primary Care Trust</td>
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<td>Torbay Care Trust</td>
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<tr>
<td>South Devon Healthcare NHS Foundation Trust</td>
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<tr>
<td>Plymouth Primary Care Trust</td>
<td>4</td>
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<tr>
<td>Local GPs</td>
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<tr>
<td>Devon County Council Social Services</td>
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</tr>
<tr>
<td>Staff of charities and voluntary organisations</td>
<td>2</td>
</tr>
<tr>
<td>Local government</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
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Table 3: Stakeholders who contacted the investigation team in writing

<table>
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<td>Patients and relatives</td>
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<tr>
<td>Voluntary organisations</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
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</table>
Appendix E: Sources of information

- Interviews and correspondence with patients, relatives, carers and members of staff of charities and voluntary organisations
- Interviews with past and present trust staff
- Observations on the wards
- Case notes and trust’s reviews of the case notes of a sample of inpatients
- Interviews with staff from Devon Primary Care Trust, South West Strategic Health Authority, Devon County Council Social Services and other organisations in the local health and social care community
- Interviews with local councillors including members of the Health and Adult Services Scrutiny Committee
- Minutes of trust meetings, including meetings of the trust’s board, clinical governance, clinical cabinet, risk management committee, executive directors meetings, drugs and therapeutics committee meetings, directorate and departmental meetings
- Reports to the trust’s board, audit committee and other trust committees
- Relevant trust policies and procedures, and policy implementation guides
- Assurance framework documents
- Reports on incidents and complaints, and information and reports from PALS
- Information on organisational, management and reporting structures at the trust
- Trust training policies and plans and details of training completed by different groups of staff
- Details of staff annual sickness levels for the trust, vacancy rates and details of posts filled on a temporary, interim or acting up basis
- Details of grievances and disciplinaries involving trust staff
- Trust staffing reviews
- Details of the number of hours worked by bank and agency staff
- Information about expenditure on staff
- Trust nursing strategies
• Information about the inpatient older people’s mental health units including details of services provided, staffing establishment and number of service users

• Waiting lists for both inpatients and outpatients awaiting assessment by the community mental health teams

• Information from the trust on serious untoward incidents in older people’s mental health services

• Details of trends analysis undertaken in relation to serious untoward incidents in older people’s mental health services and lessons learnt

• Trust community mental health team operational policy

• Trust infection control policy

• Trust safeguarding adults policy, and details of safeguarding referrals

• The trust’s strategic plan of older people’s mental health

• Details of the trust’s older people’s mental health management structures, and job descriptions of specific roles

• Details of relevant complaints regarding older people’s mental health

• Clinical audit reports

• Pharmaceutical audits

• Clinical governance documentation, such as the risk register and assurance framework, and annual reports 2006-07 and 2007-08

• Trust performance reports

• Information from South West Strategic Health Authority, Devon Primary Care Trust, Devon County Council Social Services and other organisations in the local health and social care community

• “Rule 43” letters sent to the trust as a result of coroners’ inquests involving the trust and resulting trust action plans

• Service level agreements between the trust and other organisations in the local health care community

• Relevant correspondence between the trust and other organisations in the local health and social care community

• Care Quality Commission hygiene code inspection report for the trust, published April 2009

• Department of Health, National Dementia Strategy, February 2009
• Department of Health, National Service Framework for Older People, 2001
• Department of Health, End of Life Care Strategy, 2008
• National Institute for Health and Clinical Excellence (NICE) and Social Care Institute for Excellence, ‘Supporting people with dementia and their carers in health and social care’, 2007
• Mental Health Act, 2007
• Mental Capacity Act, 2005
• Controlled Drugs Regulations in the Mental Health Act (2006)
• Healthcare Commission Annual Health Check ratings for the trust from 2006-07, 2007-08 and 2008-09
• Findings from the Healthcare Commission’s NHS Staff Surveys for 2006 and 2007
• Healthcare Commission Community Mental Health Surveys 2006, 2007 and 2008
• Healthcare Commission Review of Allegations of Bullying and Harrassment at Devon Partnership NHS Trust, January 2006
• Report of the Commission for Health Improvement’s Investigation into Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital, July 2002
• Mental Health Act Commission annual reports for 2007 and 2008
• Sainsbury Centre for Mental Health, ‘Devon Older People’s Strategic Partnership: Future Development of Mental Health Services for Older People’, April 2005
Appendix F: Glossary

**Acute illness**
An illness that occurs quickly, is intense or severe, and lasts a relatively short period of time.

**Admission**
The point at which a person begins an episode of care, for example arriving at an inpatient ward.

**Analgesic**
A type of drug which stops a patient from feeling pain.

**Anti-psychotic medication**
Medication that is normally given to treat psychiatric illnesses such as schizophrenia, severe depression or bipolar disorder. It may also be appropriately used for people with dementia with non-cognitive symptoms or challenging behaviour which causes severe distress or puts themselves or others at risk.

**Benzodiazepine**
A group of medicines used to help sleep, reduce anxiety and which act as muscle relaxants.

**British National Formulary**
A joint publication of the British Medical Association and the Royal Pharmaceutical Society of Great Britain that provides prescribers, pharmacists and other health care professionals with up-to-date information about the use of medicines.

**Buprenorphine**
This medicine belongs to a group of medicines called opioid analgesics which are used to relieve moderate to strong pain (see ‘opioid’ and ‘analgesic’).

**Capacity**
The ability to make a decision about a particular matter at the time the decision needs to be made. In this report we were particularly interested in a person’s ability to make decisions about their own health care.

**Care plan**
A written plan that describes the care and support that staff will give to a service user. Service users and, where appropriate, their carers, should be fully involved in developing and agreeing the care plan, sign it and keep a copy.

**Care programme approach (CPA)**
A standardised way of planning a person’s care. It is a multidisciplinary approach that includes the service user and, where appropriate, their carer to develop and review a care plan (including the necessary supports) that is acceptable to health professionals, social services and the person receiving care.

**Carer**
Someone who looks after their relative or friend on an unpaid, voluntary basis.
Client
An alternative term for patient that emphasises the professional nature of the relationship between a clinician or therapist and the patient.

Clinical audit
A process used to measure the quality of specific aspects of care and services and to improve that quality.

Clinical governance
A framework that ensures that organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.

Community care
Community care aims to provide health and social care services in the community, to enable people to live as independently as possible in their own homes or in other accommodation in the community.

Community mental health team (CMHT)
A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and in the community.

Controlled drugs
These are classified in various schedules depending on their therapeutic usefulness and potential for harm. Each schedule has different requirements in relation to storage, handling and record-keeping. The classifications are set out in the current Misuse of Drugs Regulations.

Many controlled drugs are essential for modern clinical care and used in a wide variety of clinical treatments. Controlled drugs include opioids such as morphine and diamorphine and also benzodiazepines (tranquillisers and sleeping tablets), anabolic steroids and growth hormones.

Crisis resolution team
A team that provides intensive support for people with severe mental illness to help them through periods of crisis and breakdown.

Dementia
A term used to describe various different brain disorders, especially affecting older people, that have in common a loss of brain function that is usually progressive. Symptoms include a decline in memory and other mental abilities to the extent of interfering with daily life and activities. When severe it can cause behavioural difficulties and dependence on care.

Diamorphine
This medicine belongs to a group of medicines called opioid analgesics which are used to relieve moderate to strong pain (see ‘opioid’ and ‘analgesic’).

Discharge
The point at which a person formally leaves services.

Drug prescription and administration chart (also referred to as a ‘drug chart’ or ‘medicines chart’)
A formal record of the medicines prescribed and administered to a patient within a particular care setting such as an inpatient setting. There is also space to record the patient’s allergy status on the drug charts. Trusts tend to develop their own format of drug charts and different
types of drug charts can exist for particular specialities. Usually these have been developed to meet different needs.

Dysphagia
Difficulty in swallowing

End of life care
This usually refers to the care of a person during the last part of their life, from the point at which it has become clear that the person is in a progressive state of decline. (See also ‘palliative care’.)

Fentanyl
This medicine belongs to a group of medicines called opioid analgesics which are used to relieve moderate to strong pain (see ‘opioid’ and ‘analgesic’).

Functional mental illness
A mental illness that is not caused by a definite physical abnormality, such as depression or schizophrenia.

Health care assistant
A non-qualified member of nursing staff who undertake assigned tasks involving direct care in support of a registered/qualified nurse.

Home treatment team (or home treatment services)
A team often consisting of a psychiatrist, mental health nurse and social worker. The team provides a mobile service offering availability 24 hours a day, seven days a week and an immediate response. The team aims to prevent unnecessary hospital admission and enables earlier discharge from hospital.

Integrated care pathway
A multidisciplinary and multi-agency approach to mapping a patient’s care from admission through to discharge and ongoing care. The aim is to pull together all the care and treatment from different health care staff and teams into a co-ordinated process making it easier for the clinicians involved to give the best care for the patient.

Learning disabilities
Impairments in specific mental processes that affect learning. The conditions can exist to varying degrees in different people.

Liverpool Care Pathway for the Dying Patient (LCP)
An integrated pathway tool used for delivery of appropriate care for dying patients and their relatives in a variety of settings. It encourages a multi-professional approach to the delivery of care that focuses on the physical, psychological and spiritual comfort of patients and their relatives. The LCP is usually used in the last 48 to 72 hours of life.

Locum
A health or social care professional who is employed on a temporary basis.

Lorazepam
A type of benzodiazepine (see) that is principally used to treat anxiety
Medicines chart
See ‘drug prescription and administration chart’

Mental Capacity Act (2005)
The law that provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

Mental Health Act (MHA) (1983 and amended 2007)
The law that allows the compulsory detention of people in hospital for assessment and/or treatment for a mental disorder.

Midazolam
An injectable benzodiazepine (see) that is generally used for sedation

Monitoring
Observing activity in relation to defined specifications, standards or targets, directly or through reports or indicators. For example, monitoring the effects of antidepressants to treat depression.

Non-executive director
A member of the trust board, who acts as a two-way representative. They bring the experiences, views and wishes of the community and patients to the trust’s board. They also represent the interests of the NHS organisation to the community.

Observation levels
The trust uses a system of four levels of observation of increasing intensity:

Level 1 - General Engagement and Supportive Observation
Level 2 - Intermittent Engagement and Supportive Observation
Level 3 - Close Engagement and Supportive Observation
Level 4 - Close Constant Observation

Occupational therapy
Uses goal-directed activities, appropriate to a person’s age and social role, to restore, develop or maintain their ability for independent living.

Opioid
For the purpose of this report the terms opioid and opiate are considered largely synonymous, with opioid being used as it has a broader definition. An opioid is a natural derivative of opium, a semi-synthetic or a synthetic substance often prescribed to manage and control pain. Examples of opioid analgesics include diamorphine and fentanyl.

Opioid naïve
Descriptors a person who has not built up a tolerance to opioids from previous administrations

Organic mental illness
Mental health conditions that arise from structural disease of the brain or from brain dysfunction caused by disease outside the brain, such as dementia or delirium.
**Palliative care**
The active total care of patients whose disease is not responsive to curative treatment. (See also ‘End of life care’.)

**Parenteral**
Taken into the body or administered by any route other than the alimentary canal, for example by intravenous, subcutaneous or intramuscular routes.

**PBR**
Payment by results

**People who use services**
This term simply means anyone who uses health services in the broadest sense. Other common terms are patient, service user and client. Different people prefer different terms.

**PDR**
Personal development record

**Pharmacological**
Related to the science of drugs, including their composition, uses, and effects.

**Plan Do Study Act cycles (PDSA)**
An approach to quality improvement that involves temporarily trialling a change and assessing its impact.

**Polypharmacy**
Polypharmacy is where a patient is prescribed four or more drugs. Prescribing of four or more drugs is not necessarily bad, and indeed may be necessary. However polypharmacy is a risk factor for potential harm from medication.

**Pro re nata (PRN) medication**
Medication given as required

**Psychiatrist**
A doctor who specialises in the diagnosis and treatment of people who have a mental health problem. Psychiatrists have undergone specialist training and may diagnose illness, prescribe medication and other forms of appropriate treatment. They also decide whether to admit people to and discharge them from hospital.

**Psychologist**
Psychologists have skills in the assessment and treatment of mental ill-health and psychological problems. Unlike psychiatrists, they are not medical doctors. Their skills include assessing cognitive functions (for example speech and thought) and providing talking interventions including psychotherapy and counselling.

**Psychosis**
The word psychosis is used to describe a group of conditions that affect the mind and to some extent mean that the person loses contact with reality. A person may experience unusual or distressing perceptions e.g. hallucinations and delusions, which may be accompanied by a reduced ability to cope with usual day to day activities and routine. Someone who has these unusual experiences is described as having a psychotic episode.
Psychotropic medication
Medication that alters perception, emotion or behaviour.

Risk assessment
A clinical risk assessment identifies aspects of a service that could lead to harm to a person who uses services or a member of staff. An organisational risk assessment looks at the general impact of actions on the overall organisation or service.

Risk management
Monitoring and changing aspects of a service or organisation in the light of risk assessments.

Section 17
The section of the Mental Health Act 1983 (and amended in the 2007 Act) that lays down how a responsible clinician can grant leave of absence to a person detained under the Mental Health Act. (See ‘Mental Health Act’.)

Serious untoward incident (SUI)
This is a term used by many health organisations to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.

Service user
Someone who uses or has used health and/or social care services because of illness or health problems. Other common terms are patient, service user and client. Different people prefer different terms.

Stepped care approach
A way of organising or planning care with separate distinct stages or steps.

Syringe driver
A portable battery-driver infusion pump used to give medication subcutaneously via a syringe.
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