

Commission for
Health Improvement
Investigations

Investigation into matters arising
from care on Rowan ward,
Manchester Mental Health
& Social Care Trust

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- staff interviewed by CHI's investigation team (see appendix C) and those who assisted CHI during the course of the investigation. In particular, Andrew Butters, Chief Executive and Pauline John, Directorate Manager, Governance at Manchester Mental Health & Social Care Trust
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- Chief Inspector Mark Linnell of Greater Manchester Police

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Executive summary

BACKGROUND

In October 2002 the Greater Manchester Strategic Health Authority contacted the Commission for Health Improvement (CHI) to request an investigation into older age services at Manchester Mental Health & Social Care Trust (the trust). This followed allegations, in August 2002, of physical and emotional abuse of patients by care staff on Rowan ward, an isolated facility housing older people with mental health problems.

The trust, and before its formation, the Manchester Mental Health Partnership, have experienced rapid organisational change. External relationships are complex and boundaries of responsibility for the quality of services are unclear. There are significant financial problems. There are internal challenges with diverse information systems and communication problems with staff due to the multiplicity of sites. The agenda to modernise services is daunting given the current level at which the trust is operating and the scale of change needed to deliver modern mental health services. Many of these issues impact on older age services.

CHI did not investigate the details of the allegations themselves as they were the subject of a police investigation, which concluded with a decision not to prosecute. The trust has undertaken an internal enquiry and disciplinary investigation. CHI looked at the systems and processes that exist in the trust and wider health community to maintain the quality of care and ensure the safety of older patients prior to and following the Rowan ward allegations. On the basis of its investigation CHI has drawn the following key conclusions about the factors that impact upon services for older people with mental health problems.

KEY CONCLUSIONS

When the allegations of abuse were made in August 2002, the trust responded promptly, proactively contacted its strategic health authority and conducted an internal inquiry. It is committed to improvement and has already implemented a number of changes. However, CHI has serious concerns about the extent of the problems and the trust's capacity to resolve them. The issues on Rowan ward and in older age services are symptomatic of other potential problems in the trust, since the systems and processes that exist to improve care and safeguard patients are largely generic across the organisation and are not working effectively.

The Rowan ward service had many of the known risk factors for abuse: a poor and institutionalised environment, low staffing levels, high use of bank and agency staff, little staff development, poor supervision, a lack of knowledge of incident reporting, closed inward looking culture and weak management at ward and locality level. The service became particularly vulnerable during the transition period when other psychiatric services were relocated to another site and Rowan ward was left geographically isolated. The trust had identified concerns about practice and had started a development programme shortly before the allegations were made in August 2002. However, there is evidence that concerns raised earlier in 2002 by ward staff were not dealt with appropriately.

The systems that should have alerted the trust to potential problems are either under developed or don't function properly. The trust's clinical governance arrangements are poorly developed in all areas, with no systematic links between components. There is no single reporting system for incidents, which hampers analysis and learning from things that have gone wrong. This may have contributed to a lack of awareness of problems in older age services.

In older age services there is very little awareness of the policy to protect vulnerable adults. Other key clinical governance policies such as consent, do not attempt resuscitation and infection control have not been standardised across the trust. When policies are agreed, dissemination, training arrangements and implementation are weak or non-existent.

Many staff feel that older age services are disadvantaged within the trust. There is little evidence of progressive practice in older age inpatient services and the trust does not put enough emphasis on patient experience. There are several mixed specialty wards for older age patients. Older age patients are cared for in wards that vary

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Executive summary *continued*

considerably in terms of environment, facilities and activities available to patients; some are unsatisfactory. The trust's culture has been described as resistant to change. There is a lack of awareness of how little progress has been made in modern multidisciplinary working and how far behind current accepted practice the trust has become.

The trust's executive nurse post has responsibility for working age adult services as well as the professional development of nursing, and this has contributed to the lack of nursing leadership and nurse development in older age services. The trust is behind with the implementation of the Essence of Care benchmarks and the new nursing strategy lacks dynamism.

The trust was formed from four trusts in three localities and in many respects still operates as three distinct sectors with different cultures. The trust has failed to unite the information systems and currently uses three separate patient administration systems. The quality of data is unreliable. Performance management is rudimentary. Staff feel that communication is poor.

The capacity in the trust's human resources (HR) department is insufficient. Staff terms and conditions and trust policies are not standardised and staff are not always informed or trained when HR policies are agreed. The trust has a significant and continuing shortage of nurses and vacancy rates are high. Recent progress has been made with recruitment of consultant psychiatrists.

The trust lacks managerial leadership at every level and management capacity is weak. Clinicians are not at the heart of decision making and the current model of clinical leadership and clinical engagement is not working. Directors have extensive portfolios without adequate support. There are confused lines of accountability. The trust lacks strategic direction and a sense of purpose and the board doesn't take enough responsibility for ensuring the quality of care.

Within the health community, older age mental health services have not been a priority and are not mentioned in the local delivery plan. Responsibility and accountability for the quality of care is unclear. Service level agreements have not been in place. There is no agreed performance monitoring framework and very limited monitoring of the quality of services by the trust, the joint commissioning team, primary care trusts (PCTs), the local authority or strategic health authority. Implementation and monitoring of the relevant national service frameworks is confused and ineffective.

The relationships between the trust and partner organisations in Greater Manchester are unsatisfactory and this impacts on the development of services. There was no agreement about how care should be delivered or what the trust should be striving to achieve when it was formed in 2002.

It is difficult to understand how approval was given for care trust status, since the partnership then, and the trust now, do not meet several of the stated criteria. The assessment that the partnership was fit to become a care trust appears to have been flawed. Establishing the care trust diverted scarce management time away from service issues and quality of care. There is no evidence as yet that the care trust has improved joint working or services for older age patients.

KEY RECOMMENDATIONS

There is an urgent need to strengthen management capacity and leadership at every level in the trust. Executive capacity and vision in clinical matters needs to be strengthened. Directors' portfolios require reviewing. Professional and managerial accountabilities need to be clearly specified and robust performance management developed. While maintaining local identities, the trust needs to engender a sense of vision, unity, common culture, direction and purpose.

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Executive summary *continued*

Clinical/service governance arrangements and capacity need urgent review to ensure they are fit for purpose. The trust needs to develop mechanisms to ensure professional staff demonstrate knowledge of, and practise, evidence based care. The audit programme should link to national and local priorities and to complaints and incidents. Audit findings must lead to change. The trust should pursue a proactive approach to the safety of patient care, ensuring risk assessment at every level and demonstrating commitment to health and safety. A unified trust wide incident reporting system is essential; it should meet national requirements, categorise incidents appropriately and be understood by staff. The trust must ensure it is following national guidance on obtaining consent and on do not attempt resuscitation decisions.

Staffing in the HR department needs to be reviewed and strengthened to deliver the effective standardisation, dissemination and implementation of key policies. There is an urgent need to ensure the vulnerable adults policy is implemented through a targeted training programme for staff.

The trust needs to develop robust information systems to support governance and to enable scrutiny of performance and outcomes.

In order to modernise practice in older age services, the trust should look at other models of care and best practice outside the local health community and seek support from appropriate external agencies to engineer change. The trust should review and clarify its position on caring for patients in mixed specialty wards. The environment, facilities and activities on wards should be of a standard that promotes good care. The trust needs to provide management leadership to develop integrated multidisciplinary working both between different health professionals and involving social care staff. This should include a review of the multidisciplinary mix, especially at ward level.

Greater priority must be given to the professional development of nursing in older age services. The trust should review the implementation of the nursing strategy and revisit the timescales and actions. Further work is required to raise expectations and progress on Essence of Care standards.

A robust performance management framework needs to be agreed as part of a service level agreement to provide a means for monitoring the quality of care. The boundaries of responsibilities in the health community for the quality of services should be established to reduce ambiguity and the risk that no organisation takes ownership. There is an urgent need to improve working relationships between the trust and commissioners and to develop an agreed vision and models of care. The partners need to work together to transform and modernise services. The strategic health authority needs to build on recent work to lead the health community towards developing transparent and effective organisational arrangements to deliver the national service frameworks and modernise care.

In any further major capital projects or re-provision development, the trust and health community partners must ensure that vulnerable services are not left isolated during the process.

The Department of Health should evaluate the process for the consideration of applications for care trust status.

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Chapter 1

Introduction

BACKGROUND

1.1 Greater Manchester Strategic Health Authority contacted CHI in October 2002 with concerns about a serious failure of care on Rowan ward on the Withington Hospital site in south Manchester, managed by Manchester Mental Health & Social Care Trust (the trust). This followed allegations of physical and emotional abuse of patients by care staff on Rowan ward, an isolated unit housing twelve older patients with mental health problems.

1.2 In December 2002 CHI announced the investigation into older age services at the trust, to look at the management systems and quality of care for older people with mental health problems, including the internal and external monitoring of the services. This remit does not include investigation of the allegations, which were the subject of a police inquiry.

TERMS OF REFERENCE

1.3 The full terms of reference are attached as appendix A.

1.4 The terms of reference require CHI to look at the trust's arrangements to guarantee the quality of care for older people with mental health problems. These cover systems to plan and deliver good care, set and monitor standards, and reduce risk to patients. This includes whether certain policies are in place and are being followed by staff. The investigation also examines the environment and culture in which care is delivered.

1.5 Other key areas to be investigated include the number and skills of staff, whether they are permanent and have had adequate supervision and training. CHI will consider the adequacy and implementation of HR policies.

1.6 Overall leadership within the trust from management and clinical staff is examined, and the extent to which doctors, nurses and other clinical staff work together. CHI will consider the way in which the trust measures and manages its performance. Finally, the terms of reference cover the role of external organisations in Manchester and the north west in monitoring the quality of care at the trust.

Additional information

1.7 The investigation has been conducted by CHI under powers set out in Section 20(1)(c) of the Health Act 1999. This empowers CHI to investigate, and report on, the management, provision and quality of healthcare. CHI's purpose in investigating a trust or other NHS organisation is to help that organisation improve the quality of the healthcare it provides, build or restore public confidence in the services provided and to help the organisation and the wider NHS to learn lessons about how best to ensure patient safety.

1.8 CHI will publish a report on the findings of the investigation and will make recommendations as appropriate to the trust and other relevant bodies.

1.9 Where recommendations are made, CHI will provide advice and assistance to all relevant organisations towards the preparation of an agreed action plan for implementation. Greater Manchester Strategic Health Authority are responsible for overseeing the implementation of the trust's action plan.

1.10 CHI will ensure effective collaboration, as required, with other organisations including Greater Manchester police.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 1 *continued*

CHI'S INVESTIGATION TEAM

1.11 The team working on this investigation was:

Ms Robina Barry, Professional Lead for Psychology, South Staffordshire Healthcare NHS Trust

Dr Nisreen Booya, Consultant Psychiatrist, South West Yorkshire Mental Health NHS Trust

Pat Evans, lay member and former carer

Dr Patrick Geoghegan, Chief Executive, South Essex Partnership NHS Trust

Margaret Irving, lay member and branch manager Alzheimer's Society, Penrith branch, Cumbria

Surrinder Kaur, CHI Review Manager (support manager for the investigation)

Louise Lingwood, Adult Services Manager, Hillingdon Primary Care Trust

Sarah McGeorge, Liaison Nurse Consultant, Mental Health Services for older people, County Durham and Darlington Priority Services NHS Trust

Derek Podesta, lay member and former carer, and trustee of Alzheimers Disease Society and Carers UK

Dr Heather Wood, CHI Investigations Manager (lead manager for the investigation)

The team was supported by :

Dr Linda Patterson, CHI medical director and lead director for the investigation

David Harvey, CHI senior analyst and the analyst team

Kristi Collins, CHI investigations coordinator

THE INVESTIGATION PROCESS

1.12 The investigation involved:

- review and analysis of documents supplied by the trust and other relevant organisations
- analysis of views of local stakeholders including relatives of patients on Rowan ward
- interviews with trust staff, including the suspended staff, during site visits and observations of facilities
- interviews with relevant external agencies and individuals

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 2

Background to the trust and to the investigation

MANCHESTER MENTAL HEALTH & SOCIAL CARE TRUST

2.1 Manchester Mental Health & Social Care Trust (the trust) was established in April 2002. It was one of the first four care trusts to be launched in England. Its predecessor organisation was the Manchester Mental Health Partnership (the partnership), which was created in October 2000.

2.2 Manchester Mental Health Partnership brought together mental health services from four organisations and adult mental health service staff seconded from the local authority. The organisations involved were: North Manchester General Hospital, the Manchester Royal Infirmary, South Manchester University Hospitals NHS Trust and the Mancunian Trust. It was established as a sub committee of Manchester Health Authority, in partnership with Manchester City Council, to provide integrated mental health services to adults in Manchester and to continue to provide NHS services to older age patients.

2.3 The creation of the health and social care trust formalised this arrangement. Social services for older people with mental health problems remained the local authority's responsibility.

2.4 The trust provides services primarily to the 392,000 Manchester residents and an estimated 50,000 people living outside Manchester who are registered with Manchester GPs. The trust provides some services to all of the metropolitan boroughs of Greater Manchester.

2.5 Manchester has a significantly younger population than the England and Wales average. There are high numbers of ethnic minority residents in Manchester local authority compared to the England average. Manchester local authority has high levels of deprivation according to all relevant measures.

Formation of the care trust

2.6 Before the establishment of the mental health partnership there was enthusiasm locally to work towards integrating health and social services in the form of a care trust. The chief executive and chair of the partnership met the minister of state for social care in July 2001, after which the partnership expressed an interest in becoming a pilot care trust from April 2002. Permission for formal consultation was given in September 2001. During the rest of 2001 the partnership prepared the application to become a care trust in accordance with national guidance, which was evolving in parallel. The assessment criteria emerged as follows: vision, standards, community involvement, corporate governance and organisational management, HR, organisational development, finance and resources, and ability to deliver.

2.7 The application to become a care trust was assessed by the NHS north west regional office, with some involvement of the Social Services Inspectorate (SSI) performance division. Regionally based policy officers with an interest in care trust policy had to review all applications and their comments were incorporated into the regional office report to the secretary of state for health. The statutory instrument establishing the care trust was signed by authority of the secretary of state for health on 22 March 2002. Further consideration of the care trust's formation can be found in chapter 6.

Current financial situation

2.8 The trust has a significant financial problem. The end of year figures for 2002/2003 show a balanced position, but this was achieved through a £4.8 million loan. The trust is overspent by 8% on its £60 million budget. Reasons given for this include a brought forward sum from a previous overspend on placements, continuing placements of patients in private and out of area beds, and the cost of bank, agency and locum nursing and medical staff. The PCTs who commission services from the trust have their own financial pressures, so there is little likelihood of increased investment from them. The local authority reports that it is prepared to examine the case for extra investment.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 2 *continued*

2.9 The trust has developed a financial recovery plan which has the support of the local health economy and local authority. This relies on avoiding expensive patient placements in the private sector. There are potential risks associated with this, since some at risk patients will have to be managed in the community for longer than would otherwise be the case. There are also financial risks associated with the recovery plan. This is discussed further in chapter 6.

Organisation of services

2.10 The trust provides services through a locality based structure. It has inpatient beds at North Manchester General Hospital, the Manchester Royal Infirmary and Wythenshawe Hospital in south Manchester.

2.11 Older peoples services include 92 inpatient beds providing assessment, treatment, rehabilitation and continuing care. These beds are located in Orchard and Cedar wards in north Manchester, in October and Cedars wards in central Manchester and in Cavendish ward in south Manchester. The continuing care beds on Rowan ward at Withington were temporarily relocated to the Monet wing of Cavendish ward at Wythenshawe in December 2002 and 20 beds will be reprovided in the independent sector during 2003. More detail about the services on Rowan ward is provided in chapter 3. The trust also has eight respite beds.

2.12 Currently there are only nine assessment beds on Cavendish ward due to the transfer of patients from Rowan ward to the redesignated Monet wing and another area for continuing care patients on Bruntwood wing.

2.13 Ward based services are complemented by a range of community and day services, including specialist dementia services.

COMMISSIONING ARRANGEMENTS

2.14 The joint commissioning executive (JCE) commissions mental health services in Manchester on behalf of the local authority and North, Central and South Manchester PCTs. Together these are the commissioners. The JCE was established in October 2000, at the same time as the partnership. These commissioning arrangements exclude social care for children and young people, and adults over working age, which remain the responsibility of the local authority.

2.15 The joint commissioning team (JCT) supports and implements the decisions of the JCE. All the PCTs and the local authority are represented on the JCE. North Manchester PCT employs the health JCT staff, holds the pooled budget and acts as the lead coordinating organisation for commissioning mental health.

2.16 Relationships with commissioners are discussed in chapter 6.

EVENTS LEADING TO THE DECISION TO INVESTIGATE

2.17 During the winter of 2001/2002, concerns within the older age directorate about the isolation of Rowan ward, staffing levels and the care of patients led to a nurse development action plan. As a result, training events for nursing staff were organised in the summer of 2002. During one of these sessions in August, staff raised general concerns about the treatment of patients. Following the intervention of senior staff, a nurse agreed to use the trust's whistle blowing procedure to make specific allegations of long term physical and emotional abuse of patients by care staff on Rowan ward. The original statement was later supported by other staff members and initial inquiries suggested that the abuse had taken several forms including hitting, slapping, stamping on feet, thumb twisting, intimidatory language and emotional abuse in the form of restricting food and playing on known anxieties of patients.

2.18 The abuse is alleged to have taken place over several years. As a result of the allegations, seven staff members were suspended. The initial suspensions were of unqualified staff. One of these was reinstated at the time of the trust investigation and investigations are still continuing into the four other unqualified staff. Two qualified staff were suspended. One was a qualified permanent member of staff about whom the allegations were not substantiated; the other was a qualified agency nurse who was not investigated further. The trust reports this nurse was not used subsequently in their services. The employing agency was not informed.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 2 *continued*

2.19 The trust notified the police as soon as the allegations were made and a police investigation was conducted. This included interviewing staff who had made allegations originally under the trust's whistle blowing procedure. The staff then made criminal justice act witness statements, which took them outside the anonymity of whistle blowing. When their investigation was complete, the police consulted with the Crown Prosecution Service about bringing a charge identified under the Mental Health Act, which relates to employee abuse of psychiatric patients. In April 2003 the Crown Prosecution Service decided not to proceed with a prosecution on the grounds that it was unlikely to prove successful.

2.20 In August and September 2002 there was a series of meetings between the strategic health authority's medical director, the trust's chief executive, the head of the JCT and the senior police officer investigating aspects of the events. The medical director took advice from the Department of Health investigations and inquiries unit and from the regional director of public health at the Directorate of Health and Social Care – North. The medical director also attended a meeting of the relatives and carers support group, which was formed soon after the allegations were made. The relatives group indicated that it would support an external review of Rowan ward that took into account governance systems and identified management roles and responsibilities in relation to any abuse that may have taken place. The trust and the commissioners felt from the outset that some form of external review was required and supported the strategic health authority's preference for a CHI investigation.

2.21 Greater Manchester Strategic Health Authority's medical director contacted CHI in October 2002 and formally requested an investigation. CHI decided to conduct an investigation and the announcement was made on the 9 December 2002.

RESPONSE OF MANCHESTER MENTAL HEALTH & SOCIAL CARE TRUST TO THE ALLEGATIONS

2.22 The trust reacted swiftly to the allegations, contacting the strategic health authority and seeking advice from the local authority on how best to implement the vulnerable adults policy. The trust undertook an internal inquiry in accordance with 1997 regional office guidance on mental health inquiries, following terms of reference agreed with the JCT. The JCT was concerned that there was some delay in safeguarding clinical notes. The trust ran the internal inquiry alongside its disciplinary investigation and the criminal investigation by the police. The disciplinary investigation was suspended while the police and Crown Prosecution Service completed their processes.

2.23 The director of nursing asked the Pennine Care NHS Trust to undertake a review of nursing care to establish the safety of patients. This was carried out by two nurses and the report was supplied to the trust in September 2002.

2.24 An interim report on the trust's internal inquiry was shared with the trust board, the commissioners and the strategic health authority in November 2002. The interim report did not fully cover all of the terms of reference since this could have compromised the integrity of the disciplinary and criminal investigations. A full report is to be produced when the other processes are complete.

2.25 The trust expanded the original nursing development action plan to include the issues that were identified by the internal inquiry and the Pennine Care nurses' report. The board receives regular progress reports.

2.26 In view of ongoing issues relating to the fabric of Rowan ward, the environment around it and difficulty with maintaining staffing levels, the trust and commissioners concluded that it was not possible to guarantee the provision of an appropriate and safe environment for patients. In conjunction with the JCT it was decided that alternative provision for care of the existing patients was a priority and patients were transferred to Cavendish ward at Wythenshawe Hospital in December 2002. The trust followed national guidance to ensure the transfer caused the least disruption and upset to patients. Two patients were discharged to alternative care and the other 10 transferred safely and adjusted well to their new environment.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 3

Quality of care on Rowan ward

ROWAN WARD – HISTORY

3.1 Rowan ward was originally based at Healey House, Withington Hospital, along with the main psychiatric services of South Manchester University Hospitals NHS Trust. Healey House is an old two storey building dating from when the hospital functioned as a workhouse. It was decided in 1999 that Anchor Trust, in the independent sector, would provide Rowan ward services in a new build facility called Monet Lodge. It was originally intended that this change would coincide with the move of the other psychiatric services to Wythenshawe Hospital in August 2001. However, the reprovision was delayed.

3.2 The other psychiatric services duly transferred to Wythenshawe Hospital in August 2001. Rowan ward remained at the Withington until December 2002 when its patients were transferred to Cavendish ward, Wythenshawe Hospital. Reprovision was scheduled for June 2003 but has been delayed. The opening date for Monet Lodge is likely to be before November 2003.

3.3 There were originally 20 beds on Rowan ward. In September 1999 the beds were reduced to 16 as part of a financial recovery plan. The ward was closed to admissions during part of 2001 and 2002 because of staffing problems. When the ward was closed permanently in December 2002, 10 patients moved to the Monet wing of Cavendish ward and two patients were discharged to nursing homes. The new facility at Monet Lodge will care for 20 patients.

DESCRIPTION OF SERVICES

3.4 Before 2000 the patients on Rowan ward primarily needed continuing care, that is, they were frail and vulnerable with many physical needs that required long term nursing care. Most of them had dementia, but a minority of patients had other conditions such as schizophrenia or depression. Although most patients were relatively long stay, some beds were used for assessment purposes. From August 2000 the ward started to accept more patients with challenging behaviour. This term is used for behaviour that includes being at times unpredictable, antisocial, disinhibited, lacking insight, unaware of danger, emotional, with repetitive habits or, on occasion, aggressive. Little training was given to staff to prepare them for this change. Although the most frail and vulnerable patients were moved to Bruntwood ward, the resulting mix of patients meant that some patients on Rowan were at risk of injury from other patients, particularly as the staff were ill prepared for the change.

Environment

3.5 The trust's inpatient older age mental health services are provided in a range of locations and different environments, from recently built units to Victorian buildings.

3.6 In 1997 and 1998 the Mental Health Act Commission expressed concern over the poor state of the environment of South Manchester University Hospitals NHS Trust's psychiatric unit at Withington. They described the wards as impoverished and neglected, despite attempts to improve their décor. In 2000 the Commission reported that effort and resources had been allocated to provide a reasonable environment. The South Manchester Community Health Council (CHC) undertook regular visits to the mental health services at Withington and recorded its dissatisfaction with the physical condition of the unit prior to the move of most services.

3.7 In 2002 the outside of Healey House was dilapidated and while Rowan ward had been partly refurbished it was old fashioned, with converted dormitories and long and wide link corridors. There were several exits from the ward, three leading outside. The layout of the ward made observation difficult. The Pennine Care nurses' report in 2002 described the décor as strikingly cold and impersonal, even though new furniture and fittings had been provided in 2001 to create a more homely and less institutional feel.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 3 *continued*

3.8 Within six months of the closure of most departments at Withington, the environment had deteriorated significantly. The physical environment degenerated due to the demolition of adjacent buildings and presence of building contractors on the site. Security was a major concern for staff, patients and carers.

3.9 The relocation reduced support and maintenance services to Rowan ward. Nursing staff felt that Healey House was a low priority for maintenance. For example, there was delay in repairing a fire exit; the estates department was called on a number of occasions to mend a lock but it was not repaired and this led to a serious incident when a patient left the building. There were also problems with the cleaning and catering contract.

Culture and philosophy of care

3.10 There has been little continuity of nursing leadership at ward level on Rowan, with five different ward managers between July 2001 and January 2003. The last two changes were attempts to bring greater stability following the allegations. Four of the ward managers were either staff acting up or internal secondments. One was the subject of disciplinary proceedings in early 2002 and received a written warning. These proceedings were not related to the later allegations. There was a lack of clarity over the professional and managerial accountability of nurses.

3.11 The physical isolation of Rowan ward from 2001 when most other services moved to Wythenshawe further contributed to staff and the CHC feeling this had become a "forgotten service".

3.12 The model of nursing care was generally old fashioned; patients' physical needs were met and they were clean, clothed, fed and kept comfortable. The Pennine Care nurses' report found standards of physical care to be generally good. Some carers, however, expressed concern about the degree of weight loss that their relatives experienced on Rowan. Some staff and relatives say they witnessed much kindness towards patients by nurses. However patients' psychological and social needs were not addressed in a systematic manner. This led to the general model of care being too institutionalised and regimented. Patients' clothing was changed and their hygiene needs addressed according to a schedule rather than when the need arose. Care was delivered to meet the needs of staff and was task orientated. There was a lack of individualised and patient centred care and insufficient involvement of carers. Team nursing was abandoned and registered nurses did not have responsibility for the planning or care of specific patients.

3.13 Admiral Nurses are specialist nurses who provide expert advice on dementia care and specific support to families caring for patients with dementia. They were asked by the lead nurse for older age services to undertake a dementia care mapping exercise in May 2002. This established a number of issues around the lack of person centred care and was one of the factors that prompted the nurse development programme.

3.14 There was little in the way of meaningful and stimulating activities for patients, as evidenced by the practice of the television being on with the sound turned down, whether or not anyone was watching it. If activities were organised they were sometimes age inappropriate and staff were uncomfortable with them. There was an activities room from January 2002 but it was generally locked and out of use. No effort was made to establish patients' individual interests and skills.

3.15 Some staff commented that Rowan ward had had a poor reputation for years and was seen as the "naughty ward" where staff were sent as a punishment.

3.16 Nursing was hierarchical on Rowan ward, and the culture was not open and learning. Team meetings largely involved the dissemination of information and instruction from the locality manager. Staff report that there was little or no opportunity for discussion. Some staff perceived a senior member of staff as being unapproachable and wanting to contain or suppress problems. They felt there was insufficient response when concerns were raised about low staffing levels and bank and agency nurse use. Concerns from some staff in April 2002 about potential abuse did not lead to effective action. Nursing assistants felt that their views were

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not valued. There was little focus on staff development. Staff felt disempowered and there was a culture of passivity. The trust's internal inquiry found that vigilance about abuse was not adequate. This may in turn have been exacerbated by uncertainty about the future of the service.

3.17 Audit in older age services was not embedded or focused at ward level and nurses interviewed were insufficiently aware of evidence based nursing practice.

3.18 Staff describe cliques amongst the nursing staff and poor relationships between individuals and groups. None of the ward managers resolved this. The atmosphere on the ward seems to have deteriorated by the time the whistle blower made allegations in August 2002. There were claims and counter claims of bullying and harassment. Senior nursing staff claim to have been threatened with industrial action if they tried to modernise practice, qualified staff felt they could not raise issues without fear of retaliation, and nursing assistants report being bullied and humiliated by some senior staff. There was no agreed trust procedure in place and the issues of bullying and harassment were not resolved. Some staff from professions other than nursing and medicine describe coming on to the ward and being made to feel unwelcome and a nuisance. The atmosphere has been described as "nonchalant" and unprofessional by some staff.

3.19 Communication including shift handovers was poor and care plans were not used as the basis of exchange of information. Day staff returning to duty might not be told about the death of a patient they were responsible for and may not know unless they read the ward diary or communication book. Staff were not always informed about the clinical problems of new patients. There was no internal rotation between day and night staff and night staff report they felt excluded from communication and development opportunities.

3.20 Many of these issues had been recognised within the service and the lead nurse for older age services set up a programme to modernise practice and develop sufficient skills to manage a ward environment with a large proportion of bank and agency staff. A steering group for Rowan ward was established and designed a staff development programme. This involved formal teaching for all staff and a management of change group for qualified staff. It was following a session of practice development in August 2002 that the allegations about abuse of patients began to materialise.

Risk management and incident reporting

3.21 On Rowan ward there was poor recording and dissemination of learning from untoward incidents. There are examples of significant injuries such as a scald and unexplained bruises not being assessed and categorised appropriately or reported. There were several instances of patients leaving the ward and putting themselves at risk which were not reported centrally. There are no central records of any accidents or incidents on Rowan ward between February 1999 and July 2002, although audit information clearly records a variety of incidents during this time.

3.22 Prior to the allegations in August 2002, completed incident forms on Rowan ward went to the line manager and then the locality manager who would decide the most appropriate response. Some incidents and accidents were being reported but these were being dealt with as health and safety rather than governance issues. Some reports were apparently going to the steering group that had been established to improve nursing care. Staff on Rowan ward believed it was sufficient to report incidents such as significant unexplained bruising in the day report book or in an accident report. Staff were under the impression that only serious incidents had to be reported centrally.

3.23 The absence of a unified reporting system for the trust bringing together incidents of all types may have contributed to the trust and directorate's lack of awareness of a problem. The difficulty was compounded by the trust not having an electronic reporting system, and having neither a health and safety officer or a risk manager at the time. The trust's internal investigation faced a significant difficulty in not being able to trace incidents across the various reporting systems and in different clinical notes.

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3.24 As mentioned earlier, there is evidence that some staff tried to raise concerns about possible abuse at an earlier stage but these were not taken seriously enough nor acted upon.

3.25 The Pennine Care nurses found there were no copies of the current health and safety policy available on Rowan ward. The health and safety folder on the ward was out of date and contained incomplete assessments such as fire checklists, moving and handling and substances hazardous to health.

Staffing levels and skill mix

3.26 In response to financial pressures, the number of funded nursing posts on Rowan ward was reduced in September 1999 from 23.9 to 18.25 whole time equivalents and the number of beds was reduced proportionately from 20 to 16. Over the next three years there were particular problems with nurse staffing on Rowan ward because of its isolation and uncertain future. When the ward manager left in summer 2001, the trust had considerable difficulty in filling the post. Since that time a number of different temporary arrangements, involving internal secondments and staff acting up, have been in place. There have been significant and sustained nursing staff shortages, with a shortfall of four E grade vacancies from June 2001 to December 2002. This resulted in the ward closing to admissions.

3.27 Around the time the allegations were made, overall nurse staffing levels appear sufficient for the number of patients. However, in total there were only three permanent registered mental health nurses (RMNs) working days and two RMNs working nights. This was clearly not adequate to ensure continuity of care. Until October 2002 the ward manager was included in the daily staffing numbers. Staff told CHI that often there was only one qualified member of staff on duty per shift.

3.28 Absence rates for nursing staff on Rowan ward ranged between 22% and 27% between 1998 and 2002, slightly above the trust average. Sickness rates were 9.8% in 2002 compared to 5.9% overall in the trust. It is recognised that national sickness rates tend to be higher in older age wards than in other services.

3.29 The use of bank nurses had increased throughout the period from April 2001 to November 2002. Most of the bank staff were nursing assistants and some were considered part of the core team at the time of transfer to Monet wing. Nursing assistants reported to CHI that they often had to show bank and agency staff around Rowan ward and explain procedures and facilities to them. They also claim that occasionally staff appeared to have no idea of the nature of the ward and were unable to respond appropriately to the patient group.

3.30 The ward manager on Rowan from 1999 to 2001 developed a local ward induction pack. This induction programme did not continue after the manager left.

Recruitment and retention

3.31 As concerns grew about Rowan ward's isolation, the trust decided to target the service with training and new staff. Nursing recruitment and retention problems were exacerbated by its isolation and the long period of uncertainty over its future. This was particularly important for the recruitment of RMNs, where a national shortage was compounded by the decision to move the service to the independent sector.

3.32 The trust set up a joint venture with Anchor Trust to recruit staff initially for Rowan ward, with a view to relocating to Monet Lodge. Although a number of people were interviewed, none took up positions. The trust approached a number of nursing agencies and one London agency was able to deliver the specification. The ward manager post was offered to a number of candidates within the organisation but none of them would accept, despite it being offered at H grade. The position was then advertised nationally and one applicant was offered the post but did not accept. A number of temporary arrangements have been in place to cover the ward manager post.

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Training and staff development

3.33 The Pennine Care nurses' report found that most qualified staff on Rowan had undertaken some further professional study. However there is no evidence that any of the nurses had undertaken any post registration specialist education in the care of people with dementia. When the nature of the patients on Rowan ward changed there was no organised programme of staff training and no specific training on the avoidance and handling of aggressive and challenging behaviour.

3.34 Nursing assistants on Rowan ward report that they were not offered training and development opportunities, other than mandatory training such as fire and moving and handling. The trust reports that some national vocational qualifications (NVQ) opportunities continued to be provided. In 2001 an initiative to improve staff understanding of modern approaches to dementia and challenging behaviour foundered when staff failed to attend. This, and the low take up of opportunities, suggests an ineffective learning culture and poor clinical governance on the ward.

3.35 As described earlier, concern among senior staff in older age services about the isolation of the ward led to a further practice development programme in the summer of 2002. The lead nurse drew up and implemented a training programme for Rowan ward staff in May 2002 covering a wide range of topics and listed the courses that staff should attend. The interim report on the practice development plan noted that the same ward staff were attending most sessions and others were not participating.

Teamworking

3.36 Each patient on Rowan ward was the responsibility of a named consultant and the service was consultant led. The consultant did a weekly ward round and would come more frequently if required. Nurses delivered the majority of care. There was little true multidisciplinary teamworking on Rowan ward. Physiotherapists visited as required and there was sporadic input from other professionals and social workers. Some staff report that staff from other disciplines were not generally welcomed on the ward and that nurses did not seek or value their contribution. There was very little psychology input, with only 0.6 of a psychology post covering all older peoples services for south Manchester. Chaplaincy services were sparse and not included as part of the ward team. The nursing and development plan includes a target for involving other professionals on the ward.

Clinical supervision

3.37 Clinical supervision brings practitioners and supervisors together to reflect on practice. An audit of clinical supervision on Rowan ward in January 1999 found that many staff lacked confidence in the supervision system. Audit reports in 2000 and 2001 record that supervision occurred, although this did not continue after the ward manager left. The lead nurse for older age services reported in June 2002 that clinical supervision as recommended by the Nursing and Midwifery Council was not taking place and tried to address this. Nursing assistants from Rowan ward told CHI that supervision often amounted to an informal conversation during cigarette breaks.

3.38 The Pennine Care nurses' report in August 2002 found that staff had differing views on supervision. The supervision form used at the time reflects a managerial rather than clinical model. In autumn 2002 the lead nurse for older age services undertook a review of clinical supervision for RMNs on Rowan. This identified a poor understanding of the purpose of clinical supervision and confusion between management supervision and clinical supervision.

Patient and carer involvement

3.39 In 1999 the locality manager initiated a relatives' support group on Rowan ward to gain relatives' views of the services. A small number of relatives attended the monthly group meetings. The group raised no major concerns about patient care prior to the allegations in August 2002. The main role of the group seems to have been to organise support for social events and fundraise for physical items the ward needed. The group also raised concerns about the future of the ward. There was little advocacy support for patients without relatives.

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3.40 In 1999 there was a complaint from a patient's daughter about an unexplained broken arm. Following the investigation an action plan was developed which included a system to record bruises on patients. There is no evidence this happened. There were 12 complaints about Rowan ward between March 2001 and March 2003. Two of these involved injury to a patient on the ward. There is a concern that some complaints made at ward level were not recorded centrally.

3.41 When the allegations were made in August 2002 the Healey House relatives' and carers' support group was established. The group has met nearly every week since then. Relatives expressed concerns about aspects of patient care on Rowan ward and lack of information. After the move to Monet wing the trust made some changes in response, particularly in respect of involvement in care planning. In the early stages after the allegations, the trust gave undertakings to produce specific information, some of which it could not deliver in the stated timescale. There has been a breakdown of trust between the relatives and the trust and contacts between them have become confrontational. The CHC and Age Concern have acted in support of the relatives. Although most feel care has improved since the move to Monet wing, the relatives have become highly critical of the trust, particularly middle and senior management, and there are continuing communication problems.

3.42 The CHC has undertaken a number of visits to older age services in Healey House over the years and provided detailed reports to South Manchester University Hospitals NHS Trust and then the partnership, before the care trust took over the services. Their main concerns related to the environmental conditions of the wards and day areas and staffing shortages. The CHC noted that the trust had made improvements to the décor in 2002.

Care planning and the care programme approach

3.43 Before the allegations, registered nurses were responsible for organising care programme approach (CPA) meetings on Rowan ward, completing the forms and ensuring patients or carers signed them. Audits of the documentation in 2000 and early 2001 show full compliance with completing the Manchester care assessment schedule (MANCAS), which was used to assess and record for CPA purposes. However, this audit did not deal with the quality of information from the assessments. Staff shortages may have impacted upon the quality of assessments. There were also problems with sharing the contents of care plans with colleagues and carers. There were no further audits on Rowan until after the allegations in August 2002, when major shortcomings were identified. These included a lack of patient centred focus, no personal biographies, interventions not individualised, and insufficient identification of risk. CHI identified problems with information sharing and effective involvement of carers, and lack of involvement of non qualified staff; nursing assistants were not aware of care plans or their content at this time.

Impact of transfer of other services to Wythenshawe Hospital

3.44 In August 2001 all clinical services except for Rowan ward and the day hospital for older age patients moved from the Withington site to Wythenshawe. Not only were these services left geographically isolated from surrounding medical and surgical services, but there was almost no mental health presence on the Withington site. The CHC reported in October 2001 that staff were conscious of being there on their own and in April 2002 commented that staff felt they were "working on a building site". The canteen closed and staff were unable to have hot food. The CHC praised the improvements to the kitchen and lounge in July 2002, but noted there were still problems with the supply of clean linen.

3.45 Clinical services were also affected by the move. The departure of acute services meant that from September 2001 there was no emergency resuscitation team on site. The trust addressed this by training Healey House staff in advanced cardiopulmonary resuscitation (CPR) and the use of emergency services via 999. Unwell patients had to transfer to accident and emergency units. This, while appropriate and normal in such situations, was seen by some staff as a deterioration in service and reinforced their sense of isolation. Staff told CHI of delays in duty doctors coming from Wythenshawe after patients had fallen or when nurses were concerned

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about their health. They felt the ward was seen as low priority. There was no longer a mortuary facility and the trust engaged the services of local undertakers, as is the practice in many small community hospitals. The CHC report in July 2002 queried why staff were receiving no help with the management of methicillin resistant staphylococcus aureus (MRSA). This seemed to have been resolved when they visited again in November 2002.

RECENT PROGRESS

3.46 Patients were moved from Rowan ward to the Monet wing of Cavendish ward in Wythenshawe Hospital in December 2002 because of concerns about the viability of the ward. Monet wing is a temporary location until the patients move to Monet Lodge later in 2003. Monet wing was previously the therapy unit of Cavendish ward and provides a bright and clean but cramped environment. Six patients from Rowan ward sleep on Monet wing and four others sleep on Cavendish. There are separate Monet wing staff allocated to these patients. At the time of the CHI visit in April 2003 one of the two toilets had been out of operation for some time. There is no bathroom dedicated for use by patients on Monet wing, although bathing facilities are shared with the adjacent Cavendish ward. The day room on Monet wing also functions as a dining room, although it is too small for all 10 patients to sit there in comfort. It is bare and impersonal, as are the bedrooms. There is no room available on Monet for a private discussion or for relatives to meet in a quiet environment, although a room is available on Cavendish. The environmental conditions will be improved when the patients move to Monet Lodge.

3.47 During the initial phase of the internal inquiry the trust modified the original action plan to improve nursing and patient care. It specifies expected care standards and new assessment procedures. In November 2002 the Manchester care assessment schedule (MANCAS) 65 assessment was introduced. This assessment is age relevant, more patient centred and considers life histories and preferences. Successive audits have demonstrated increasing compliance with the standards and greater involvement of relatives, particularly after the move to Monet wing. Most patients have up to date care plans and regular monthly reviews, in which relatives or advocates are involved. The plans are more comprehensive and patient centred and personal biographies are used. The cramped conditions, however, limit the activities that can be undertaken and there is a culture of risk avoidance, discouraging patients from doing things for themselves.

3.48 Recruitment for Monet Lodge has gone well. CHI understands that the Anchor Trust has recruited over 40 staff for Monet Lodge.

3.49 Improved staffing levels and supervision have created a more positive atmosphere. Team nursing has been reintroduced. There has been a significant increase in numbers of nurses per shift. Night staff report 10 staff on duty at night for the 28 patients in Monet, Cavendish and Bruntwood. There continues to be heavy use of bank and agency staff but these are mainly long term staff in order to ensure consistency of care. Bank nurses working at night still do not get any induction. There is as yet little multidisciplinary teamworking and no regular input from psychology to the ward.

3.50 There is still poor communication with night staff and no internal rotation. Night nurses report that they are not involved in care planning, even for problems that occur at night.

3.51 The trust and commissioners recognise that advocacy arrangements are not yet adequate. Following the trust's request, Age Concern has been providing advocacy for Rowan ward patients who do not have any relatives. They have also provided support for the relatives' group.

QUALITY OF OTHER INPATIENT SERVICES

3.52 Staff describe Cavendish ward at Wythenshawe, which is an assessment ward, as having an open and welcoming atmosphere. Different grades of nursing staff report good communication, excellent opportunities for development and feel that their views are valued. The ward is bright, cheerful and clean.

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3.53 Bruntwood ward, which is part of Cavendish, houses seven very frail patients, all with multiple nursing needs, who are likely to be in hospital for the rest of their lives. CHI is concerned that the physical environment of this ward is inadequate for the number and the needs of the patients. The ward is very clinical, with little attempt to make it homely and inviting. The small sitting area is a converted two bed bay with small windows that are too high for patients to look out of, two hand basins, two kitchen trolleys and no space for any activity. The large functional bathroom is shared with Cavendish ward; it has no blinds or curtains, and doubles as a store for linen skips and the hoist. The environment lacks any stimulation; patients only ever see their bedrooms, the lounge and occasionally the bathroom and are in their beds for long periods.

3.54 CHI visited the inpatient wards in north and central Manchester. These vary in terms of environment, facilities and activities available to patients. Activities are often limited by staff availability and patient mix. Some detail is provided in the paragraphs below.

3.55 Orchard ward in north Manchester is a continuing care ward with very dependent patients. During the CHI visit the ward environment was generally clean and tidy. Some clocks were one hour slow. The equipment was up to date but a hoist needed servicing and a bed in one of the single rooms had been broken for some time. The estates department had been notified. A power cable in one dormitory trailed across the cubicle floor. Staff were very busy and appeared under pressure; without the day care staff the situation would have been worse. Staff focused mainly on the physical care and comfort of patients. There is an alarm to warn staff if a patient is trying to open the door to the outside. A loaded cage type goods transporter was left in the lounge all morning. There was no apparent individual activity or group activities in ward area. Staff find it impossible to organise activities due to personnel shortages. The day care unit had an art class on the upper floor but this was inaccessible due to a broken lift. The day centre has a fully equipped sensory room.

3.56 Patients were going on a day trip when CHI visited Cedar ward in north Manchester. The ward was noted to be clean and tidy, there were pictures on walls, including some of earlier outings, and fresh flowers. The staff patient interaction that CHI observed was respectful and positive.

3.57 October ward in York House, central Manchester, was very drab and dilapidated with shabby paintwork and carpet covered in cigarette burns. At the time of one CHI visit, the female toilets were clean but the male toilets were unflushed. Although there was a wall chart of activities, these are often limited by staff availability. Staff were not aware of any patients attending day events or craft groups. Staff communication with patients was observed to be good.

3.58 On Cedars ward in central Manchester, a nurse had been employed to develop a day hospital service. This had not developed as planned and the day patients are treated as extra numbers on the ward and the nurse makes up the staffing complement. Community psychiatric nurses are not making new referrals because there are no special activities for these patients. Cedars ward was being redecorated when CHI visited.

3.59 CHI had the opportunity to see the Phoenix Centre Day Hospital at the Minehead Resource Centre. This is a bright new building and there are plans for a garden therapy area.

KEY FINDINGS

Detailed key findings that are replicated in other chapters are not listed here.

1. Many of the known elements that indicate a risk of abuse were to be found on Rowan ward: geographical isolation, poor environment, low staffing levels, high use of bank and agency staff, little staff development, poor supervision, reduced support from the rest of the trust, lack of knowledge of incident reporting, closed inward looking culture and weak management at ward and locality level. There were also staff factions and little continuity of ward leadership. The trust had identified concerns about practice and had instituted a programme of practice development shortly before the allegations were made in August 2002. However, there is evidence that concerns raised earlier that year were not dealt with appropriately.

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2. There was no specific training to support the change to looking after patients with challenging behaviour. The model of nursing care was too regimented and task oriented.
3. There has been a breakdown in confidence and trust between the relatives' support group and the trust.
4. Team nursing has been reintroduced on Monet wing following improved staffing levels and supervision.
5. The environment on Monet wing of Cavendish ward, while an improvement, is still impersonal and unsatisfactory because of cramped conditions which severely limit activities. Other inpatient wards for older age patients vary in terms of environment, facilities and activities available to patients. CHI has serious concerns about the quality of the environment for patients on Bruntwood ward.

RECOMMENDATIONS

Recommendations that apply across older age services are not replicated here.

1. The trust needs to continue to improve patient centred care for this group of patients, building on the recent reintroduction of team nursing.
2. The trust, relatives' group and the CHC need to build bridges in the best interests of patients and the future of the service.
3. The trust should review the suitability of the environment for the patients currently on Bruntwood and consider its options.
4. In any further major capital projects or re-provision the trust and health community partners must ensure that vulnerable services are not left isolated during the process.
5. The trust should work with the Anchor Trust and relatives to ensure a smooth and safe transfer of patients to Monet Lodge.

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Chapter 4

Arrangements to improve and monitor quality and reduce risk in older age services

4.1 While the focus of the investigation was on older age services, many arrangements for quality assurance are generic across the trust. In order to investigate the arrangements in older age services, CHI examined the trust wide systems and processes for assuring quality, emphasising specific issues that particularly impact on older age services.

4.2 Clinical governance is the system adopted by the NHS to ensure that patients receive the highest possible quality of care. The core components of clinical governance assessed by CHI are patient involvement, clinical audit, clinical effectiveness, use of information, risk management, staffing and staff management and education and training. This chapter looks at the first five components, incorporating progress on care planning and the national service frameworks (NSFs) under clinical effectiveness. Staffing and training are considered in the next chapter.

SERVICE/CLINICAL GOVERNANCE ARRANGEMENTS

4.3 The trust uses the term service governance rather than clinical governance, to include social care, as it is a health and social care trust. It defines service governance as the arrangements and responsibilities for continuously improving the quality of services. There is a directorate of service governance and a director who chairs the governance committee, which is a standing committee of the trust. The committee meets every two months, approved minutes are circulated to board members and a report presented at every board meeting. The service governance committee has sub committees covering its major functions. Service users and carers and the CHCs are represented on the committee.

4.4 The clinical governance functions in the directorate include professional accountability, risk management, service (clinical) audit, education, training and continuing professional development, research and development, quality and effectiveness, incident reporting and complaints, the care programme approach (CPA) and the Mental Health Act. A small team, some of whom have only been appointed recently, seeks to deliver this substantial agenda. In addition to the half time director (who is also the medical director) there is a directorate manager with responsibility for governance coordination and serious incident reporting. The corporate services manager coordinates complaints and legal claims. There are trust wide managers for CPA, the Mental Health Act and service audit. A research and development manager and an education and training manager have recently been appointed. There is no further infrastructure for the delivery of governance, although professional leads and HR support some governance activity. The trust reports it is planning to appoint a risk manager and complaints and incidents coordinator.

4.5 The trust was unable to cover the governance manager's post while she was on maternity leave.

Philosophy and organisation of care

4.6 In several wards that provide older age inpatient services at the trust, patients with functional illnesses such as depression and schizophrenia are cared for alongside patients with organic or cognitive problems such as dementia. There are debates within mental health services about the appropriateness of mixing different client groups. Current accepted practice is to care for the different patient groups separately. Among patients with a diagnosis of dementia, there are some patients who are mobile, disturbed and aggressive and others who are frail and immobile. To successfully manage different categories of patient, it is important to have thorough risk assessment, staff who are appropriately trained, and a physical environment that permits adequate care. CHI heard mixed views from staff in north and south Manchester on this issue (central Manchester has separate wards). Some staff also expressed concern about combining day care patients with longer term inpatients on a ward.

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Chapter 4 *continued*

Involvement of patients and carers

4.7 The trust involves service users in committees and has established carer support groups, as did its predecessor, the Manchester Mental Health Partnership. It is a key objective of the trust to improve service user and carer involvement. A strategy for service user and carer involvement is not yet in place but is to be developed. There are user and carer non executive directors on the board, and user and carer representatives on the risk management group and the service governance committee. At most levels in the trust there is evidence of user participation in working age adult services; however, as CHI did not review these services we cannot assess their impact. Many of the wards in older age services have or are establishing some forum for carers, which operate with varying degrees of success. A service user has been identified as a lay older persons champion but there is no management champion.

4.8 The trust acknowledges that advocacy arrangements need strengthening across older age services and reports that work is ongoing with the joint commissioning executive (JCE) to develop these services.

4.9 There is a patient advice and liaison service (PALS) steering group. PALS is under resourced and to date has been limited. CHI is concerned that due to the extended sickness of the PALS coordinator, their administrative assistant has been asked to coordinate the service without adequate preparation or support. The trust reports that the service has been enhanced by the appointment of a voluntary services coordinator.

4.10 Central, north and south Manchester CHCs have observer status at the trust board, as do voluntary sector representatives. South Manchester CHC is also represented on the service governance meetings and on the group to consider the move to Monet Lodge, along with the Healy House carers'/relatives' group.

Complaints

4.11 The trust has a complaints procedure based on national policy that has been recently revised to make it more user friendly and to conform to the risk pooling scheme for trusts.

4.12 The trust board receives a quarterly report of complaints; complaints about older age services are reported as a separate section. Prior to the allegations there had been few formal complaints about older age services. Between April 2000 and September 2002, 14 reports on older age services complaints were produced. The main themes identified were care and treatment, and staff attitude and behaviour, but these did not lead to recommendations and action plans. The trust reports it has recently adopted a new complaints policy which generates an action plan in a standard format. It is not specified how these will be monitored. There is no systematic mechanism for complaints to trigger audit.

4.13 There is non executive involvement in the delivery of complaints training. Over 200 staff have had training, about a quarter of whom are ward nurses. The PALS coordinator had received very limited complaints training at the time of the CHI visit; they were, however, advising people about making complaints under the policy.

Service audit

4.14 The trust uses the term service audit for activity that elsewhere would be called clinical audit. There is one manager supporting audit in the trust with limited additional support from service managers. The service audit plan was attached to the service governance report that went to the board in February 2003, where it was noted. The trust acknowledges that the development of audit has been slow, in part because of the level of resources transferred from the acute trusts.

4.15 The trust acknowledges that further development in audit infrastructure and choice of topics is required. The programme is not determined by national priorities or by the NSFs. There has been one joint audit of bed usage with primary care and there are plans to agree a future cycle of audit activity. This will include audit of primary to secondary care protocols. There is no formal mechanism or system to link audit to complaints or incidents that would allow a trust wide audit to be triggered by a trend analysis of complaints, for example.

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There is no evidence of a link between clinical effectiveness and audit. Such a link would help ensure that guidelines and standards are automatically audited. Some audits of drug prescribing and administration have been prompted by the lack of guidelines. Several medication audits have triggered reaudits, which is to be commended. There are some examples of change following audit but no systematic process.

4.16 Audit is mainly medically driven and there is little multidisciplinary audit.

4.17 The only audit training has been drop in sessions run by the audit manager for interested staff. These are said to be poorly attended.

Effectiveness and evidence based care

4.18 The trust identified the strengthening of systems for quality control as a priority area for 2002/2003. They planned to achieve this by the use of standards, guidelines and evidence based practice, and by learning from local and national audit. As yet there is little evidence of progress or of research findings being translated into improved patient care in older age inpatient services. The governance department is compiling a list of guidelines and procedures in use across the hospital sites in order to standardise these. A start has been made on prescribing guidelines.

4.19 Nursing policies and guidelines are being collated. There are examples of guidelines being present in several versions as a legacy of the organisation being formed from four trusts and the local authority. This can lead to inconsistencies in care. There is little to demonstrate widespread knowledge of evidence based nursing care in older age services.

Implementation and monitoring of the national service frameworks

4.20 There is little evidence of systematic implementation and monitoring of the NSFs in the health community (see chapter 6). The trust drew up action plans in response to the NSFs for older people and mental health but there has been no regular reporting on progress to the board. There is no strong leadership or accountability for NSF monitoring externally or internally, and they have not been used to drive change. There is a confused system of performance management with different people taking responsibility for the NSF delivery and targets. Most staff interviewed by CHI were confused about the NSFs; some had not even heard of them. CHI was told that progress is slow on some of the targets that relate to older age mental health services including single assessment. There has been no internal audit of progress against the NSF targets. The trust reports that an audit of the NSF for older age is now being undertaken.

Medicines management

4.21 A medicines management sub committee reports to the governance committee. The group advises on prescribing and more general medicines management, and provides support on implementing national guidance on medicines. The committee meets every two months and has user and carer representation. In April 2002 it was noted in an audit report that as yet there were no agreed prescribing guidelines. However, the trust reports that some guidelines were in place by March of that year. A medication errors group was established in May 2003.

4.22 One of the trust's policies deals with covert administration of medicine, such as giving medication to a patient in a cup of tea. The practice is only allowed following a strictly described procedure, when multidisciplinary discussion has taken place, relatives have been involved and documentation completed. There was a significant incident involving covert medication on Rowan ward.

4.23 A number of trust wide audits in 2000 and 2001 showed prescribing at higher doses than recommended and polypharmacy, prescribing a mixture of drugs when fewer would be better. The trust felt the results were comparable to other similar organisations. Quality control audits in 2002 highlighted prescribing errors associated with poor documentation and out of date versions of the *British National Formulary* being used on the wards. An audit in 2003 to see if the hypnotics policy was being followed, revealed discrepancies between

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hypnotics prescribed and administered on adult acute wards. Recommendations ensued and a reaudit was advised. An audit in spring 2003 showed that unqualified staff commonly give medicine on adult and older age wards. Audits and reaudits in the last two years have demonstrated medication errors on admission, with drugs omitted and/or changed for no documented reason. Some of these were potentially serious. These audit results have been widely shared at meetings but the mechanism for achieving and monitoring change in practice is unclear.

Care planning and the care programme approach

4.24 The care programme approach (CPA) should be used to coordinate the process of assessment, care planning and the review of care packages. It is mandatory for working age adult services and the principles should apply in older age services. In 2001 the partnership's older age directorate set itself the target of collaborating with social services to integrate CPA and care management and develop a single joint assessment tool. The trust reports there has been agreement to use the Manchester care assessment schedule (MANCAS) as the primary mechanism for assessing need, but that a fully integrated set of processes and documents is not yet in place. A key part of the NSF for older people is to develop single assessment. The Department of Health guidance requires health and local authorities to develop a single assessment process for all older people and for this to be in place by April 2004. The local authority is confident this will be achieved but this confidence is not generally shared by others in the trust and externally.

4.25 In October 2002 the trust produced a detailed update on CPA and care management policies and procedures. These replaced the policies from the partnership's component organisations. The trust CPA has a locally developed needs assessment, MANCAS, and a needs assessment for older people called MANCAS 65. More serious cases require a full assessment, an enhanced CPA, appointment of a care coordinator and a safety profile.

4.26 While recent progress has been made, CPA is not yet integrated across the trust for either adult or older age services and different systems are in existence. There are differences between the localities and between the wards and the community mental health teams. The trust has developed a common CPA documentation system to replace the separate systems in place for each of the predecessor trusts. However, trust audits confirm that few sites have complied with the new system and parallel systems continue to exist. There are also some issues of consultants wishing to maintain their local system.

4.27 Central Manchester developed a computerised patient record and CPA system. Poor IT infrastructure is hindering progress in integrating CPA. Even within central Manchester staff have to use specific terminals to input data and some of the staff in older age services do not have the IT skills to use the software. A small number of access points for inputting data have been provided in north and south Manchester. Once care plans are on the system they can be viewed from any site. However, frequent problems are reported with the underlying computer network system, making access to electronic records frustrating. An audit in February 2003 in adult services found that fewer than 50% of 140 inpatients had a care plan on the computerised system. This illustrates that CPA is not yet integrated and the computerised system is not yet effective.

4.28 The trust acknowledges that the integration of CPA systems across community and inpatient sites is incomplete, in part because of network infrastructure problems. An audit in February 2003 showed that community mental health teams provided ward staff with a copy of the MANCAS assessment in only 11% of adult admissions, although the teams knew 80% of patients before admission. Only 22% had a CPA review held or planned since admission. It is rare for patients on day units to get CPA. CHI heard varied reports of the extent to which CPA is embedded in older age services. In some areas relatives are closely involved and receive copies of the documentation but this is not always the case.

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Use of information

4.29 The trust has an information management and technology (IM&T) strategy, which was agreed when it was still a partnership in April 2001; it is now being revisited. The strategy describes many complex and uncoordinated data processes such as referrals and assessments and client tracking systems. There have been difficulties with integrating the three different patient administration and record systems from the partnership's component organisations, which has hampered progress. Staff may also be on one of five different networks, depending on where they work, and there are three email systems. The social services systems are incompatible with the health systems.

4.30 It is not clear if the trust board is aware of the importance of information and information systems to support governance and performance management. There is an absence of robust information across the trust and there are widespread concerns about data quality. There is no agreed performance management framework encompassing information on quality. While the board receives reports on complaints and incidents, there are no formal standards or quality indicators reflecting clinical priorities regularly reported to the board.

4.31 Staff have concerns about their lack of IT skills. The trust reports IT training is available via the Manchester NHS Agency and that brochures have been circulated to managers. The trust's website needs updating and it reports that it has a contract with the agency for this. There is no trust intranet and not all areas are connected to the internet. Only 60% of NHS personal computers were networked in 2001. An electronic newsletter is under construction. The trust acknowledges being behind with e-learning. Like other trusts in the north west, it is awaiting an e-learning pilot.

4.32 The trust does not have a city wide policy for case notes, having inherited five different systems. The trust has audited note keeping standards. There is not, as yet, a unified health record for patients and the design of records varies. As is generally the case, professions keep their own notes in hospital and in the community teams. There is no consistency in the way doctors and nurses file their notes. In central Manchester and one ward in south Manchester a joint nursing/medical note system is in place. Compliance with multidisciplinary records is a requirement for level one of the clinical negligence scheme for trusts (CNST) and the trust reports it is identifying the actions needed to achieve this.

Risk management and incident reporting

4.33 The trust has risk management structures and processes but they are under resourced, uncoordinated and poorly implemented. The trust has not yet achieved level one of CNST, because it has not met their standards.

4.34 There is a risk management strategy, written by the risk management group, which reports to the governance committee. The trust is now establishing a new risk management committee as a sub committee of the board. CHI is unclear about the relationships between these groups, and also with the scrutiny committee (see 4.40). The risk strategy was approved by the board in April 2002. There is no risk manager and this is one of several reasons why the trust has not achieved level one in the clinical negligence scheme for trusts. The trust has not yet developed a risk register. The trust reports it has recently decided to purchase an integrated reporting system and risk register module; it has also agreed a new post of risk manager.

4.35 The trust acknowledges that some procedures drawn up at corporate level are not always implemented at service level. The trust considers that the difficulty in assuring policies are implemented across the trust is a consequence of having staff on multiple sites. There has been some recent specific risk training for older age services to attempt to address this.

4.36 Although a serious untoward incident (SUI) reporting system was established when the partnership was created, there is continuing confusion among staff about accident and incident reporting. There has been a lack of communication to staff about the processes to follow in the event of a serious untoward incident. There is no electronic reporting system for incidents and reports are collated by hand. In April 2002 there was a

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presentation of an electronic system at a governance meeting but this was felt to be inappropriate. In December 2002 the governance committee noted that an integrated reporting system was needed as matter of urgency. The local accident and incident forms were inherited from the three acute trusts and there are still three systems in place. There has been an inconsistent approach to recording and reporting incidents.

4.37 Until August 2002 incident forms were sent to the line manager and onto the locality manager who would decide the appropriate response. As previously mentioned, the lack of a unified reporting system is likely to have contributed to the lack of awareness among trust management of a possible problem on Rowan ward. Currently all incidents across the trust are reported to the relevant service director. Most are then referred to the health and safety manager but serious ones go to the governance directorate manager for investigation.

4.38 Staff appear unable to distinguish categories of incidents and degrees of seriousness and speak of SU1 forms for all accidents and incidents. This runs the risk of devaluing serious incidents and overloading the reporting system. There is a concern that the emphasis has gone too far from learning lessons from incidents to simply reporting them.

4.39 Commissioners have expressed concerns for a number of years over the reporting, investigating and learning of lessons from serious incidents, starting from a time when South Manchester University Hospitals NHS Trust provided services in the south, through to the present day. The trust reports that the joint commissioning team (JCT) requires them to use a system for incident reporting that was developed some years ago. There has been recent agreement to review the system. The trust must also report serious incidents to the strategic health authority electronically using an executive information system. The trust reports that it has had no feedback from this process. The strategic health authority state in their clinical governance development plan for 2003/2004 that they will share lessons from this information system.

4.40 The trust established a SU1 scrutiny committee with membership from non executive directors and commissioners. It receives all incident reports including near misses and looks into how these have been investigated. Each report, including recommendations, is reviewed and either accepted, returned for further work or a group is constituted to revisit an incident. Although this scrutiny committee has been in existence for some time, there is little evidence of root cause analysis to identify underlying problems and wider systemic failures. Most staff report that they get little feedback from incidents, whether serious or not. The functions of the risk management group, committee and scrutiny committee potentially overlap, which creates confusion.

Health and safety

4.41 The trust uses a health and safety policy that was agreed by the Manchester Mental Health Partnership. Each site has a local health and safety committee reporting to the trust health and safety committee, which in turn reports to the board. One of the trust's objectives for 2002/2003 was to review, update, implement, train staff and monitor its health and safety policies and procedures. This has not yet been achieved. A health and safety adviser was appointed in December 2002, but had a period of extended sick leave in the spring. The priority of the adviser is to implement an integrated reporting system.

4.42 There are many instances of different health and safety policies in the three localities, stemming from the original acute trusts. Some policies, such as stress, have been standardised but there has not yet been any training. Despite a health and safety poster being displayed in some wards, most staff interviewed on older age wards were largely unaware of any relevant health and safety policy.

4.43 The Health and Safety Executive noted in 2002 that risk assessment procedures needed development. In 2003 they asked for information on the trust's control and restraint policy.

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Vulnerable adults

4.44 Following the publication of *No Secrets*, the national guidance on preventing abuse of vulnerable adults, the trust adopted Manchester's city wide policy for vulnerable adults in October 2001. The multiagency policy requires regular audits to be done but, as yet, the trust has not conducted any. The trust has not yet benchmarked their reporting rate against comparable trusts.

4.45 When the allegations were made, the trust acknowledged that local procedures were not in place and levels of expertise were low, so it sought advice from social services as the lead agency for the protection of vulnerable adults policy. Social services advised early involvement of the police, to separate the strands of criminal and disciplinary investigations and any external and internal inquiries. The trust followed this advice.

4.46 The Pennine Care nurses' report indicated concern about the limited extent of implementation of the original policy within the care trust. This included incident reporting, staff awareness of the policy and the trust's links to statutory services.

4.47 The trust has now developed a local implementation procedure for the national *No Secrets* policy. This was first taken to the board in September 2002 and finally ratified in April 2003. The staff side continue to have reservations about early involvement of the police as required by the policy. The trust document states that all staff are expected to be aware of the possibility of abuse of vulnerable adults and to know how to report their concerns. However, CHI found that most staff interviewed working in older age services have limited or no understanding of the protection of vulnerable adults policy, even after the allegations around Rowan ward. There was no evidence of multiagency guidelines on any of the wards and nurses could not identify the trust's lead person for vulnerable adults. As yet there has been no inhouse monitoring of progress on the implementation of this policy.

4.48 The trust recognises the need to improve staff knowledge of the risks to vulnerable adults and the procedures in place to report concerns. Management briefings are scheduled for September 2003 and staff training for later in the autumn. The trust states the procedure has been incorporated in the corporate induction programme.

Infection control

4.49 The trust does not have a trust wide infection control programme or its own infection control team. The host trust on each site provides an infection control service via a service level agreement. There is some variation between the sites. This can produce conflicting advice to staff, which is discussed in the next chapter.

Control and restraint

4.50 The trust provided CHI with a copy of the policy on restraint that had been in operation at South Manchester University Hospitals NHS Trust and an undated copy of the partnership's draft policy on control and restraint. Control and restraint is also referred to as 'care and responsibility' and as 'the therapeutic management of violence and aggression'. The undated policy states that all staff will receive training in control and restraint, obtain a certificate of competence and undertake annual training updates.

4.51 During 2000 and 2001 some staff on Rowan ward were taught control and restraint by a member of staff who was not accredited to deliver this training. In summer 2002 senior staff in older age services expressed concern that the earlier policies were inappropriate for older people. The lead nurse for older age services and others worked on a draft which was circulated for consultation in July 2002. This version was accepted and it was agreed that staff should be released for training. This policy has been implemented locally but has not been endorsed by the trust board. There is a form on which staff should record the use of control and restraint techniques.

4.52 Following the allegations, the trust concluded that there had been some inappropriate use of restraint techniques and stopped these practices immediately.

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Chapter 4 *continued*

Consent

4.53 Staff told CHI about various nursing strategies to engage patients in care. However, they had low levels of knowledge about consent and the legal basis of day to day care delivery. The trust has no general consent policies or guidance other than for the administration of electroconvulsive therapy and covert medication. National guidance required a consent policy to have been in place in by October 2002. To meet the requirements of CNST this must be addressed. The trust reports this work is now underway.

Resuscitation

4.54 There is not yet a comprehensive cardiopulmonary resuscitation (CPR) policy for the trust and it relies on policies from the three acute trusts. There is no central monitoring of CPR training although previous records are being entered on a database. There is a draft policy on how to decide and record when resuscitation should not be attempted.

KEY FINDINGS

1. Based on its investigations of older peoples services, CHI found that clinical governance systems are under developed in all components, particularly audit, effectiveness, risk and use of information. Systematic links between areas such as complaints and audit are not established. Information systems are very poor. There are significant capacity issues in many components including audit and risk management.
2. Involvement of patients and carers needs strengthening. A strategy for patient and carer involvement is not yet in place. PALS is under resourced and to date has been limited. There are very restricted arrangements for advocacy for older age patients. Issues from patient and carer complaints have not consistently led to action and follow up.
3. The trust has several mixed specialty wards for older age patients but does not appear to be clear about the rationale for combining patients with different diagnoses and care needs.
4. Audits have shown a number of problems with the prescribing and administration of medicine across the trust. Although information about these has been disseminated, and in some cases reaudits conducted, there is no evidence of mechanisms to ensure change of practice.
5. There is little evidence of systematic implementation and monitoring of the NSFs that are most relevant to older patients with mental health problems.
6. Despite progress, the care programme approach is not yet integrated across the trust. There is little confidence that a single assessment process will be in place by April 2004.
7. There is still no unified reporting system bringing together all types of incidents. Trained staff appear unable to distinguish between categories of incidents and degrees of seriousness and refer to SUI forms for all accidents and incidents. There is little learning from complaints or incidents. Risk assessment is not established. Policies vary across localities. A start has been made on improving health and safety and standardising policies but as yet there is limited progress.
8. Most staff interviewed who work in older age services have limited or no understanding of the vulnerable adults policy. There is a lack of knowledge across the trust of the risks to vulnerable adults and of the procedures in place to report concerns. The control and restraint policy for older patients has not been finalised and relevant staff are not trained.
9. There is no overall consent policy or CPR policy and the do not attempt resuscitation policy is not yet agreed.
10. Key policies such as infection control are not yet standardised. New or revised procedures are often designed at corporate level; subsequent roll out and training are limited or non existent and the procedures are not always followed.

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Chapter 4 *continued*

RECOMMENDATIONS

1. Clinical/service governance arrangements and management capacity need urgent review to ensure they are fit for purpose. The trust needs to develop robust information systems to support governance and to enable scrutiny of performance and outcomes. PALS and advocacy services need to be strengthened.
2. The trust should look at other models of care and best practice in older age services outside the local health community and seek support from appropriate external agencies to engineer change. The trust should review and clarify its position on caring for older age patients in mixed specialty wards. It should ensure that where this happens the environment allows for adequate care including the separation of individuals or groups if this proves necessary. The review should encompass day and inpatients, people with functional and organic mental illness, challenging and frail patients, and identify which patients do not need to be cared for in a hospital environment.
3. The trust needs to develop mechanisms to ensure staff in older age inpatient services demonstrate knowledge and practice of evidence based care and translate research into action. The audit programme needs to link to national and local priorities and to complaints and incidents. The medication audit programme needs to lead to measurable improvements in prescribing and administration of medicines.
4. Transparent arrangements and clear accountability are needed to deliver the NSFs targets.
5. Further effort is required to ensure compliance with a standardised care programme approach.
6. The trust should pursue a proactive approach to the safety of patient care, strengthening risk assessment at every level and demonstrating commitment to health and safety. A unified, trust wide incident reporting system is essential; it should meet national requirements, categorise incidents appropriately, be understood by staff and provide feedback that illustrates the value of reporting.
7. There is an urgent need to ensure the effective implementation of the vulnerable adults policy through a targeted training programme for managers and staff.
8. Infection control policies need to be standardised across the trust.
9. All frontline staff should receive appropriate training in control and restraint.
10. The trust must ensure that it has agreed and implemented trust wide policies on obtaining consent and do not attempt resuscitation decisions, and that these are consistent with national guidance.

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Chapter 5

Staffing and staff development

5.1 While the focus of the investigation is on older age services, many arrangements for staffing and staff development are generic across the trust. In order to investigate staffing issues in older age services, CHI examined the systems and processes for staffing and staff development, emphasising specific issues that impact on older age services.

CAPACITY IN HUMAN RESOURCES

5.2 The trust has a capacity problem within HR. This has hindered the task of bringing together the services and staff from different NHS trusts and the local authority, which all have different services and staffing arrangements. The trust has recently appointed an associate director of HR. At the time of the CHI visit, there were two senior advisers, one of whom was acting head of HR, who were both supported by an adviser. There were concerns from many quarters about how poorly HR was functioning and its impact on the organisation and on older age services. Progress is slow in harmonising policies across the trust. There are more than six different staff employment contracts operating across the organisation and little progress has been made on unifying terms and conditions. Staff also complain of administrative errors in processing applications and in dealing with new starters.

Harmonisation and implementation of policies

5.3 A timeframe for harmonisation has not yet been achieved although there is agreement on the order of priority. Progress has been delayed by lack of capacity as mentioned above and poor working relations with the staff side. Staff are therefore working with policies that predate the formation of the partnership and the trust and may be out of date. There are also policies on wards that are labelled draft, which is confusing for staff. Each part of the trust has its own sickness policy, which is particularly difficult for management. The trust has not yet standardised a non attendance policy.

5.4 HR policies agreed across the trust include disciplinary and grievance, misconduct and professional misconduct, bullying and harassment, whistle blowing, recruitment and retention, the protection of vulnerable adults and organisational stress.

5.5 Even when policies are agreed, dissemination and implementation is often ineffective. There is insufficient capacity to train and support managers in the use of policies such as protection of vulnerable adults, and limited capacity to give advice on issues such as vacancies, sickness and absence management.

Staffing levels and skill mix

5.6 There are no patient dependency measures in place in older age services to help determine reasonable staffing levels and skill mix, and staff are dubious about the value of such an exercise in the present financial situation.

5.7 The trust and its predecessor organisations have had considerable difficulties in recruiting and staffing to agreed levels over periods of time. In the 1999 South Manchester University Hospitals NHS Trust staff survey, only 43% of staff were satisfied that their area of work was adequately staffed and only 37% of qualified nursing staff were satisfied. In November 2002 the Mental Health Act Commission described a significant shortage in nursing staff, particularly qualified staff. The vacancy level was 25%. At times wards have had to close because of nursing shortages. There are other older age wards in the trust where only one qualified member of staff is on duty during a shift.

5.8 There is inadequate staffing in occupational therapy, especially in older age services, and the south of the city has been particularly disadvantaged. Clinical psychology staffing in older age services is insufficient and unevenly distributed across the localities, with only 0.6 of a whole time equivalent post in south Manchester and more than three whole time equivalents in central Manchester.

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5.9 The number of staff and proportions of qualified nursing staff have been addressed on Monet wing, with use of bank and agency staff. The trust now has a full complement of older age psychiatrists.

Recruitment and retention

5.10 The trust recently agreed a recruitment and retention policy.

5.11 Although recruitment generally within Manchester mental health services is problematic, recruitment in the trust is reported to be better than at neighbouring trusts. This may be due to the trust's profile as one of the first four care trusts in the country. There are also links with the University of Manchester, which may be attractive to a range of professional groups.

5.12 Good progress has been made recently on the recruitment of consultant psychiatrists, with just four of 16 vacancies remaining. There were three vacant consultant posts in older age services in November 2000 but the trust now has a full complement.

5.13 Recruitment of nurses is generally difficult. However, there are areas with no shortages, such as Cavendish ward at Wythenshawe Hospital, where a combination of educational and developmental opportunities and a supportive culture makes employment attractive.

5.14 The trust reports that newly recruited staff are subject to registration checks where applicable and to Criminal Record Bureau checks. However, there is no trust wide protocol for checking professional registration and therefore there is potential for variable verification practice. Staff are employed before criminal checks are returned to avoid losing staff, although the trust reports a robust reference process is used before employment starts.

5.15 Exit surveys and interviews with staff who are leaving have taken place since 2001. Since the process began 31 staff have returned their questionnaires. Normally interviews are with the individual's line manager but may be requested with HR. The trust intends to take a six monthly report on exit trends to the executive management team.

Use of bank and agency staff

5.16 The use of bank and agency nursing staff throughout the trust is high. The joint commissioning executive (JCE) expressed concerns about this in November 2001. The proportion of the staff budget spent on bank and agency staff and overtime for unqualified staff is currently 30%. The trust is unable to provide a detailed breakdown of the reasons for this usage. As yet there are no trust wide criteria for equitable covering of staff shortages and no policy for the use of one to one observation on wards, although the trust plans to develop these. Procedures for authorisation of agency staff are to be revised and negotiations are continuing with the staff side on the introduction of a city wide nursing bank.

5.17 Efforts have been made to book bank and agency staff on a long term basis to limit the impact on continuity of care. Staff in older age services describe some bank and agency staff as good, and indeed catalysts for change, others as uninvolved and adding to the difficulties faced by permanent staff.

5.18 Some staff told CHI the use of agency staff in south Manchester has increased due to the sickness policy in that locality, which has restrictive limits on sick pay.

5.19 The trust requires bank staff who have no previous connection with the trust to bring their Nursing and Midwifery Council card to interview, and positions are offered subject to acceptable references and an occupational health assessment. Routine checks are not made with the Nursing and Midwifery Council.

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Chapter 5 *continued*

Induction

5.20 The trust has a short but comprehensive corporate induction programme which is positively rated by staff. However, some senior nursing staff in older age services are unaware of this programme. Most key issues are signposted during induction including complaints, incident reporting, protection of vulnerable adults, child protection and the whistle blowing policy. Multicultural issues are not covered, although there is an intention to do so.

5.21 The clinical negligence scheme for trusts (CNST) assessment praised the city wide induction day for doctors in training.

5.22 Local induction at ward level is variable. Staff surveys in 2001 and 2002 show about half of all staff were satisfied with the departmental induction they received. The trust has a checklist of items to be covered by bank and agency staff at the start of a shift if they are unfamiliar with the clinical area. Induction is poor for bank staff.

Appraisal and continuing personal and professional development

5.23 The trust reports it is developing a continuing professional development plan for all professional staff. The trust states that many professional staff employed by the trust undertake performance appraisal within their professional structures, in a framework determined by the professional governing bodies and agreed by the trust. The framework within nursing is being developed to cover all grades of staff but this is not yet complete. Medical appraisal has been in place since 2002. For some consultant staff there is joint appraisal with the University of Manchester.

5.24 The trust does not have a trust wide system of managerial appraisal or a performance review procedure. An appraisal policy has not been agreed; it is being discussed with staff side representatives. The trust has developed a personal development plan template and is developing an approach to appraisal within team structures.

5.25 The trust is unable to provide details of numbers or percentages of staff who have had appraisal. Most staff interviewed by CHI had either not had an appraisal or had not had one recently. Staff report that night staff do not have appraisal.

5.26 In the 2001 staff survey, 39% of staff said they had an agreed personal development plan. In the 2002 survey, only 34% reported having an agreed plan for the following year.

EDUCATION AND TRAINING

5.27 The Manchester Mental Health Partnership did not have a training manager post and relied on service level agreements with training providers. This arrangement was not adequate for a coordinated approach to training. The CNST assessment commented on aspects of training arrangements and awarded a score of 50% for the induction, training and competence standard. There is no centrally recorded system for attendance at training courses, workshops or conferences, although some local systems are operating. The trust is working on a central system.

5.28 The partnership brought in a training manager on secondment who analysed training needs and produced an education and training strategy in 2001. This originally started for working age adult services, and particularly around community health teams, but has widened its focus. The trust has recently appointed a training and development manager.

5.29 The partnership had a draft training strategy on delivering the national service framework (NSF) for mental health. This was a two year project from April 2000 to March 2002. The document acknowledged that inpatient training and staff development had been neglected over many years.

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5.30 The trust has yet to systematically analyse training needs. The training and education plan does not link to a detailed analysis of training needs by individual. The training needs analysis was derived from focus groups, untoward incidents and complaints and information from appraisal, which the trust acknowledges is incomplete. This relates in part to the lack of a comprehensive appraisal programme. The staff survey in 2002 found that 52% of staff were satisfied with their input into identifying their training needs. The trust reports that the untoward incident procedure does identify training needs and they plan to introduce a systematic review of training needs to incorporate learning points from incidents and disciplinary cases.

5.31 There is some local debate about what constitutes mandatory training in a health and social care trust. There are three different models of mandatory training and three service level agreements. Most staff in older age services report they have had mandatory training such as fire, cardiopulmonary resuscitation and moving and handling, but not always on a regular basis. The trust acknowledges the monitoring system for mandatory training is inadequate and reports that a new system is currently being piloted.

5.32 There is a concern that skills improvement in older age services is being sidelined by service imperatives. It can be difficult to release staff from the wards to attend training. The trust says it plans to introduce protected learning time but has not yet been able to implement this. It is difficult for night staff to access training and development opportunities and they are not always told about course dates.

5.33 After a period of organisational change when nursing assistants had restricted access to national vocational qualifications (NVQs), the trust now provides a range of opportunities for these staff. Training and development opportunities for clerical and non nursing staff are limited.

5.34 There has been no training for managers on HR policies and their implementation, including absence and sickness management, despite these being significant problems across the trust. Training on the protection of vulnerable adults policy is scheduled for managers in September 2003.

5.35 Sessions on complaints handling have been conducted and since December 2001 there have been two half day training sessions on investigating serious untoward incidents.

5.36 The provision of infection control services and accompanying training from three different sources means that staff encounter different approaches, particularly as agency staff may work in more than one location. This can be confusing for staff and was worrying for relatives of patients on Rowan ward, who were given conflicting messages about methicillin resistant staphylococcus aureus (MRSA) and the care of patients with MRSA. The infection control services are covered by service level agreements which are not sufficiently clear about the service to be delivered.

5.37 A study leave policy that applies across the trust has not been agreed. The trust has been working on defining local managerial responsibility for allocating study leave and how this links to appraisal. Staff receive protected time for agreed programmes of training such as NVQs. Staff told CHI that study leave is sometimes cancelled at short notice due to staffing shortages on the wards in older age services.

DEVELOPMENT OF NURSING PRACTICE

5.38 The director of nursing is also the director for working age adult mental health services. CHI considers both of these roles demanding and time consuming, leaving little time for taking forward the leadership and development of nursing in older age services, which suffered as a consequence.

5.39 The support for the professional development of nurses comes from a practice development team that was established in November 2001. This team consists of the lead nurses for both directorates and the practice development nurses for community and working age adult inpatient services. There is no nurse executive group, but there are a number of groups working on different elements of nursing. An older age professional forum was established in October 2002. Some staff report that the remit of this group is not clear. There is a regular

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meeting of F and G grades from across the trust which concentrates on operational and management issues such as budget management. Despite this, many nurses reported to CHI that they had no opportunity to meet their peers across the trust or to debate clinical issues in nursing or evidence based practice.

5.40 CHI is concerned that the development of nursing in older age inpatient services has been neglected. There are few senior clinical nurse management posts. Although there are examples of adequate inpatient care, particularly on cavendish ward, there is little evidence of innovation or modernisation of nursing practice. There is no structure for ward managers to meet with the director of nursing. There is little exchange of staff between localities to learn and spread good practice.

5.41 A nursing strategy has been in development for some time and was recently agreed. It is due to be launched in autumn 2003. Few staff in older age services knew of, or were involved in, the nursing strategy despite a programme of road shows. The strategy includes action points on developing nurse leadership but it lacks dynamism and authority, and the action points have no timescales or are out of date.

5.42 The trust says it has identified management development as a priority and part of the role of the training and development manager will be to support this. A number of nursing staff including from older age services have been part of the Leading Empowered Organisations (LEO) training. However, there is a need for consolidation of clinical and management development and there is no succession planning for key posts.

5.43 Most qualified nursing staff report good access to training and an improvement over the last year. Some are concerned that in house training is not always clinically relevant and that there is little access to training courses of specific relevance to older age services.

5.44 The trust acknowledges it is at an early stage of implementing the Essence Of Care benchmarks. The trust reports that 20 nurses (out of 120) from older age services attended training on Essence of Care and that older age services are leading the trust on these standards, but CHI found that the majority of nurses interviewed in older age services are only vaguely aware of the concept. There has been a slow start to benchmarking and trust expectations are not challenging. Little has been done to develop practical nursing skills.

5.45 Some night staff report that they miss out on memos, documents, training, job opportunities and inclusion in various groups.

5.46 A practice development nurse post was recently approved for older age services and there are plans to recruit to an agreed nurse consultant post in the future should resources permit.

5.47 There is little use of standardised mental health assessment tools or models in nursing practice. The trust reports that person centred care is the trust's model of working with people with dementia, but this was clearly not the case on Rowan ward. CHI found that nursing staff were largely unaware of a theoretical framework for nursing assessment and care.

CLINICAL SUPERVISION

5.48 The trust does not yet have a formal model of clinical supervision in place and supervision appears to be at an early stage for nurses in older age services. There is some confusion as to what is meant by supervision and in some cases clinical supervision is rolled in, or confused with, managerial supervision. Each site has a different approach to supervision. The trust reports that a model is under development and that a training programme started after the CHI visit.

5.49 Supervision procedures are in place for allied health professionals and psychologists. Junior doctors comment positively about their training and supervision.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 5 *continued*

TEAMWORKING

5.50 A review by the Kings Fund in 1998 of all mental health services in Manchester commended strong multidisciplinary working. There seems to have been little progress in older age services since then and the trust has been left behind. The culture of care in older age services is outdated. CHI is concerned by the slow development of a modern multidisciplinary approach to care and the lack of staff understanding of the extent to which their practice lags behind elsewhere. Staff still work almost entirely within professional structures.

5.51 Multidisciplinary teamworking does not appear to be consistently embedded across older age services. The care programme approach (CPA) is seen as a nursing responsibility rather than a shared one. There is variation between the localities and multidisciplinary working is described as being strongest in central Manchester. In some instances attempts to involve a wider range of professionals may be frustrated by lack of resources. CHI frequently heard that older age services were medically dominated, particularly in the south, where Rowan ward was located.

5.52 There is currently no formal integration of social care staff at any level in older age services or plans for their integration being developed. There are some good individual working relationships between social care and health professionals, and NHS and local authority day services are located together in south Manchester. However, some health staff are concerned about the difficulties in accessing their social care counterparts. Health staff find the referral system from health to social care bureaucratic because referrals have to be made to a central system before being relayed to the relevant locality or service. The local authority, however, respond that the dedicated contact centre acts as an efficient filter and referrals are straightforward. The lack of integration of seconded social care staff in adult services highlights the need for improved teamworking. These staff reportedly do not feel valued by the trust.

5.53 The community mental health teams for older age services have no single point of access, with different bases and separate referral systems. The teams are more accurately described as a group of separate professionals working in the community. There is no evidence of integrated notes or joint case working. The strategy for older people envisaged having community mental health team managers in place by April 2002 but this has not happened. Little progress has been made in this area.

5.54 At the time of CHI's visit, the multiprofessional development group for older age services had not met for six months.

5.55 On Monet wing doctors and nurses still largely determine an individual's care. The culture of care is outdated, with little occupational therapy or psychology input. CHI learnt there is some resistance to pharmacists attending ward rounds. Although working relationships are generally described as good, there is very limited genuine multidisciplinary teamworking.

SUPPORT FOR STAFF

5.56 One of the trust's objectives for 2002/2003 was to achieve the Improving Working Lives standard for HR strategy and management, equality and diversity, communication and staff involvement, flexible working, healthy workplace, training and development, staff benefits and childcare. Progress was slow until the chair took over responsibility and the trust was awarded practice status in May 2003. The trust intends to include Improving Working Lives in the annual report and will create a dedicated webpage.

5.57 In the 2002 staff survey, 64% agreed that the trust provided family friendly flexible working arrangements. Childcare facilities are good but access to subsidised places is not equal across sites.

5.58 The trust's recently agreed stress policy refers to arrangements for the mental health partnership. There are no trust wide arrangements for staff with stress. Staff can access counselling through occupational health, via three separate locality agreements, but not all staff are aware of this. There is no independent counselling service that staff can access directly. There is no trust welfare officer, although the chaplaincy offers a pastoral role on request.

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Chapter 5 *continued*

5.59 The Rowan ward allegations were devastating for staff and some feel the trust did not provide adequate support. Some night staff felt they were not adequately briefed during this period, although the trust had arrangements in place. Suspended staff feel that they were not offered sufficient support by the trust in the initial weeks after the allegations.

RELATIONSHIPS WITH THE STAFF SIDE

5.60 Relationships between management and the staff side are poor. Staff side representative arrangements are complex following the merger. Some of the problems reportedly relate to personality clashes between senior HR staff and union representatives. The lack of constructive working relations is impacting on issues such as the harmonisation of terms and conditions for staff and the agreement of policies. A contract of employment for the new trust has still not been agreed and has had to be imposed by management. There is substantial work to be done to agree trust wide policies but apparently little will to do so.

HR POLICIES

5.61 Many HR policies differ from site to site.

5.62 The trust has a whistle blowing policy which was approved by the partnership board in December 2001 and has since had numerous revisions. There are four individuals, including a non executive director, with whom staff can raise concerns if they cannot discuss them with their line manager. There has been no training for the named staff or for middle managers on dealing with these concerns.

5.63 In the 2002 staff survey, 60% of staff felt able to feed back to their line manager, but fewer than half the respondents reported that they thought staff generally felt free to express their views and concerns.

5.64 The trust reports that it is the responsibility of senior managers to ensure staff are aware of policies. Since the internal inquiry the governance team have visited each site to publicise all governance policies, including the whistle blowing policy, which is part of the induction programme. When earlier claims were made in April 2002 about treatment of patients on Rowan ward there was a lack of action and support at middle management level.

5.65 The trust board adopted the disciplinary procedure in February 2002, after protracted consultations with unions. In the 2002 staff survey, 92% of staff indicated they had read, or were aware of, grievance and disciplinary procedures.

5.66 CHI has concerns about the handling of grievances immediately prior to the allegations, including inconsistencies in procedures and a failure to maintain comprehensive documentary records. There are also concerns about some aspects of the disciplinary proceedings. For example, it is unclear how and if decisions were made and recorded about informing a nursing agency about the suspension of one of its qualified staff.

5.67 There is no agreed trust wide sickness policy, despite sickness being a significant issue that adds to staffing and financial problems.

5.68 The trust adopted an anti bullying and harassment policy in December 2002. The 2002 staff survey found that 86% of staff had read or were aware of the harassment and bullying policy, and 61% were confident that effective action would be taken to tackle bullying.

5.69 Until the trust wide anti bullying and harassment policy was adopted the trust used existing policies. Action taken in response to claims of bullying and harassment on Rowan ward was insufficient given the potential to lead to a harmful patient environment.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 5 *continued*

KEY FINDINGS

1. There is a severe lack of capacity in the HR department. Relationships with the staff side are unsatisfactory. These factors have contributed to problems with harmonising terms and conditions and policies across the trust. Some key policies are not in place, including a policy for the management of sickness. Even when policies are agreed, subsequent dissemination and training and implementation are limited or non-existent.
2. There has been recent success in recruiting consultant psychiatrists. In older age services there are ongoing nurse staffing problems and high use of bank and agency staff without agreed criteria. Registration checks are not adequate. Staff value the corporate induction programme but at local level it is variable and poor for bank staff.
3. A continuing personal and professional development plan for all professional staff is being developed but there is no agreed appraisal policy.
4. A training strategy has been produced. Staff are now generally appreciative of training opportunities although training and development had been neglected over recent years. Training is not yet coordinated and there is no systematic training needs analysis. Mandatory training differs across the trust and attendance at mandatory and other training has not been monitored centrally. There is inconsistent training and support in some areas due to different service level agreements, and there is a lack of clarity over the content of service level agreements.
5. CHI is concerned that the development of nursing in older age services has been neglected. Although there are examples of adequate inpatient care, there is little evidence of innovation or modernising nursing practice. The nursing strategy is not authoritative or dynamic. Further work is required to raise expectations and progress the Essence of Care standards. There is no formal model or standard for clinical supervision in place in the trust and supervision appears to be at an early stage of development in older age nursing. There are few opportunities for nurses to meet their peers and discuss clinical issues and evidence based care.
6. There has been little development of a modern multidisciplinary approach to care in older age services and there is limited awareness by staff and management of the extent to which their practice lags behind elsewhere. Staff still work almost entirely within professional structures. There is no leadership for older age community mental health teams and their mode of operation is outdated. There is no formal (or informal) integration of social care staff in older age services. Social care staff in adult services have not been successfully integrated, despite structural change.
7. The trust has recently been awarded practice status for Improving Working Lives.
8. CHI has concerns about the operation of the trust's grievance and disciplinary systems.

RECOMMENDATIONS

1. Capacity in the HR department needs to be reviewed and strengthened, outstanding policies need to be agreed and disseminated and implemented effectively. Management and the staff side need to pursue a joint agenda of modernising older age services.
2. The trust must progress the development of equitable criteria for covering staff shortages and procedures to authorise the use of agency staff. Arrangements for checking professional registration and providing local induction need strengthening and standardising.
3. The trust needs to develop a robust appraisal system that contributes to systematic training needs analysis and professional development.

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4. The trust needs to review progress on delivering its training strategy to ensure its objectives are being met and that it is relevant to all staff. Work to coordinate and monitor training and attendance requires ongoing support. Specialist and multidisciplinary training for staff working in older age services needs development. Service level agreements for training must be clear and consistent. Infection control training should be standardised.
5. Greater priority must be given to the professional development of nursing in older age services. The trust should review the implementation of the nursing strategy and revisit the timescales and actions. The director of nursing needs to establish regular contact with senior nurses at ward manager level and above. Action is required to progress formal clinical supervision for nurses. Further work is required to raise expectations and progress Essence of Care standards.
6. The trust needs to modernise the way in which it provides care. Strong leadership is necessary to develop up to date multidisciplinary working arrangements and transform the culture of care. Leadership and modernisation is needed for the community mental health teams and to ensure the integration of social care staff.
7. The trust needs to process grievance and disciplinary proceedings in accordance with best practice and improve its record keeping.

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Chapter 6

Partnerships and external monitoring

FORMATION OF THE CARE TRUST

6.1 The criteria for care trusts were being developed and released in parallel to the application process. This was against the backdrop of reorganisation at regional level with the dissolution of regional offices and creation of directorates of health and social care and strategic health authorities.

6.2 With hindsight it is difficult to see how the mental health partnership could have been assessed as meeting many of the criteria to become a care trust. This applies particularly to the criteria around standards, HR, organisational development, finances and ability to deliver. There was no detailed financial risk assessment at regional level. The trust reports that their own financial risk assessment did not foresee the transfer of risk on out of area placements. The standards for becoming a care trust included the requirement for robust information systems to be in place to support high quality clinical and other operational processes and this activity had to be monitored. There also had to be clear and effective risk assessment and management processes in place, and ongoing successful HR management including staff development. None of these are in place now and they were not in place before March 2002. In their self audit tool for care trust application the trust reported progress and assurances were given that these areas would be addressed. Manchester Health Authority supported the proposal.

6.3 The trust and the joint commissioning team (JCT) carried out a best value review of adult services in February 2003. It stated that clear advantages exist from integrating services. However, it noted there were different cultures within the trust and a lack of a coordinated vision, and that service accessibility needed to improve. CHI is concerned that establishing a care trust diverted scarce management time away from services and vital governance arrangements. Individuals inside and outside the trust told CHI that partnership working and older age services have yet to feel the benefit of the formation of the care trust. Social care staff for adult services are not yet integrated; there are conflicts between medical and social models, professional barriers, and little true multidisciplinary working.

ROLE OF THE LOCAL AUTHORITY

6.4 The local authority, Manchester City Council, has commissioning and provider responsibilities for mental health. It has delegated most of these provider responsibilities to the trust via legal agreement. As the trust is a care trust there are local councillors sitting on the board as non executive directors. There is a perception that these elected members may see themselves as local authority representatives rather than independent board members with collective responsibility for the trust. The local authority states that councillors on care trust boards have a complex role as they have to represent both organisations. However, they are primarily there to represent the public. Stakeholders in the health community were unsure of the extent to which the city council feels ownership of the issues facing the trust.

COMMISSIONING ARRANGEMENTS

6.5 The joint commissioning executive (JCE) commissions mental health services in Manchester on behalf of North Manchester PCT, Central Manchester PCT, South Manchester PCT and the local authority. The JCE was established in October 2000, at the same time as the partnership. These commissioning arrangements exclude social care for children and young people, and adults over working age.

6.6 The joint commissioning team (JCT) implements the decisions of the JCE. All the PCTs and the local authority are represented on the JCE. North Manchester PCT acts as the lead coordinating organisation for commissioning mental health services and employs the health JCT staff. The head of the JCT manages the pooled health and social services mental health budget. The trust now attends meetings of the JCE, following recognition of the importance of considering the trust's views and concerns about communication problems.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 6 *continued*

6.7 There is also a joint monitoring committee which consists of PCT chief executives and non executive directors, the director of social services, an elected member of Manchester City Council, the head of mental health joint commissioning, and the chair and chief executive of the trust. The committee's remit is to be examined to ensure it is operating effectively.

LOCAL DELIVERY PLAN

6.8 Local delivery plans are the new planning framework for the NHS and form part of a three year planning cycle for health and social care. Each strategic health authority has to integrate the local delivery plans of all the trusts within its boundaries and there is one overall plan for each strategic health authority area. Once agreed, the plan forms the basis of the Department of Health's performance management of the strategic health authority.

6.9 The strategic health authority states that the key areas of concern emerging from the local delivery planning process in 2003 were mental health and the workforce in general. The strategic health authority intends to tackle the issues in mental health with a new strategic framework for mental health that will include a review of information systems. The 2003/2006 local delivery plan does not contain any reference to older age mental health services.

STRATEGIC DIRECTION FOR OLDER AGE MENTAL HEALTH SERVICES

6.10 There is a history of difficulty in getting agreement from key stakeholders on a vision for the future of older age services.

6.11 The process to decide the future of older age services has been long and drawn out, and is seen differently by the various participants. Following consultation, the decision was taken by the original joint commissioning board to move the services provided by Rowan ward to the independent sector. There was disagreement from some stakeholders over this proposed change, particularly from some of the clinicians. Although the decision was taken in 1999, the agreement with Anchor Trust to reprovide services took a long time to finalise because of complex issues such as the number of sites, land ownership and planning consent. The contract was not signed until 2002. This delay added to the uncertainty for staff and relatives over the future of the service.

6.12 In November 2001 the JCE produced a health and social care strategy for older people with a mental health need. This followed a series of stakeholder conferences and focus group meetings in 1999 and 2000. The focus group programme was attended by 23 organisations, representing 39 different departments. The strategy included a three year implementation programme. Most of the actions were to be developed within existing resources, others required additional funding or further work to identify resource implications. The trust considers that the strategy did not establish a route map for progress and many of the proposed developments were unrealistic without substantial extra resources.

6.13 The JCT established a stakeholder group for older people in May 2002 as a sub group of the JCE and in support of MANLIT, the city wide local implementation team for the National Service Framework (NSF) for Older People. MANLIT representatives from users and carers, the voluntary sector, social services, primary care, the independent sector and mental health providers, including consultants. Its purpose is to influence the future development of services and scrutinise progress, particularly in the light of the mental health and social care strategy and the NSF for Older People. The stakeholder group reports directly to the JCE. The strategic health authority has also stated an intention to form an older people's network. It is not clear if this will replace the stakeholder group.

6.14 The strategic health authority has begun work to develop a strategic framework for mental health services.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 6 *continued*

NATIONAL SERVICE FRAMEWORK IMPLEMENTATION AND MONITORING

6.15 The organisational arrangements in Greater Manchester to deliver and monitor the NSFs for mental health and for older people have not been transparent or robust. Responsibility and accountability for both are confused. The NSFs do not appear to be used locally as a driving force to achieve change. Further details are provided in the following two sections.

National Service Framework for Mental Health

6.16 The strategic health authority and previously the Directorate for Health and Social Care (DHSC) use a detailed set of annual self assessments by local implementation teams to monitor the NSF for Mental Health.

6.17 In early 2000 it was envisaged that the joint commissioning board would function as the local implementation team for Manchester. In October 2000 mental health services across Manchester transferred to the mental health partnership, and commissioning became the responsibility of the JCE, on behalf of the PCTs, health authority and local authority. The local implementation team for mental health did not meet for over two years and has only recently been reinstated with a meeting in April 2003. The commissioners acknowledge the lapse of the local implementation team should not have happened. Some senior staff in Greater Manchester Strategic Health Authority were not aware that the team had not met.

6.18 The local implementation plan exercise to establish a baseline for mental health services included a self assessment exercise. Clinical staff in the trust are concerned that they have insufficient involvement in the returns that commissioners make on progress to the strategic health authority and DHSC. The JCT report that the care trust is involved in compiling the returns, and the trust states that they have responded formally where they feel the information is incorrect.

6.19 The strategic health authority recognises that progress has been slow on the mental health NSF and is developing a model for how they will be implemented in future. The DHSC acknowledges there were more concerns about mental health NSF progress and delivery in Manchester than for other areas. Discussions between the strategic health authority and DHSC for performance reviews focused on the financial position, not the NSFs, and the authority states it was not made aware of its position in comparison to other areas.

National Service Framework for Older People

6.20 The local implementation team for the NSF for Older People across Manchester is MANLIT. This meets every three months. There is a locality sub group in each PCT area. The director of older age services was a member of MANLIT. However, CHI was told there is no link to older age psychiatry, and consultant psychiatrists cannot explain to CHI what is happening in their own local implementation team. The strategic health authority acknowledges it currently lacks information on the effectiveness of the older age implementation teams, and this is being addressed. Since the NSF for Older People is more recent than the NHS for Mental Health, and there are fewer specific targets, the process is less developed and there has not been any specific monitoring. In terms of monitoring, older age services have been generally lower in priority than acute services or working age adult mental health services; older age mental health services are even lower. It has been described as "the Cinderella of Cinderellas".

6.21 The strategic health authority acknowledges that momentum for the NSF for Older People has, to some extent, been lost. There is little evidence of achievement or progress in older age mental health services. The local delivery plan does not contain any targets specifically for older age mental health services. There is no baseline information for single assessment and the steps to achieve the April 2004 target have not been outlined. The NSF agenda has been swamped by policy imperatives such as NHS funded nursing care and there has been no resource to support its implementation. The strategic health authority is conscious of its lack of knowledge about older people's services and has recently set up a process to address this. It has strengthened its expertise and capacity to deliver the NSF for Older People and plans to establish an older people's network by autumn 2003.

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Chapter 6 *continued*

WORKING RELATIONSHIPS

6.22 The PCTs and the local authority commission services through the JCE and this leads to confusion around lines of accountability. Stakeholders interviewed by CHI are unclear about the respective roles and accountability of the JCT and JCE, and the JCE and PCTs and the local authority. The strategic health authority adds another layer of complexity. The strategic health authority and local authority consider the accountability to be clear and devolved to the PCTs and subsequently, the JCE. However, the lack of clarity on responsibility was particularly noticeable when organisations were asked about their responsibility for assuring the quality of care on Rowan ward.

6.23 Many of the people CHI interviewed spoke of a serious breakdown in relationships between the commissioners and the care trust. Personality differences between key individuals in the trust and the commissioning body, and past perceived injustices, colour discussions and prevent constructive engagement. This breakdown in relationships has had a major impact on how services are commissioned and developed.

6.24 There are concerns within the trust that the JCT is too involved in operational issues and does not listen to the views of professionals. Consultants have a range of views on the future shape of services but generally feel their views are not sufficiently valued. They are concerned that commissioners make decisions that are not based on evidence. Commissioners do not share this perspective and in turn feel frustrated by the lack of progress in areas where agreement has been reached. There are also concerns from GPs about the service they receive from the trust, particularly in adult services.

6.25 The JCE declared in March 2001 that developing a service level agreement with the partnership was a priority. It was decided that the agreement should be used as a method of establishing what was expected of the partnership in the first year. In May 2001 it was agreed there should be a separate service level agreement for older people's services. Work on a performance management framework began but it has not been taken forward. Discussions continued throughout the year and the service level agreement for adult services was signed at the end of the 2001/2002 financial year. There was no formal service level agreement in place for older age services that year or for either service in 2002/2003. Service level agreements for 2003/2004 have not been signed for adult or older age services.

6.26 Tensions have been exacerbated by the financial situation. The financial recovery plan relies heavily on stopping out of area placements in private beds. There are potentially serious risks associated with this, as some at risk patients will have to be managed in the community for longer than would otherwise be the case. Although there is some evidence of risk assessment by the trust, the level of detailed assessment is not clear to CHI. There are also issues around the extent of risk sharing with health community partners. As yet there has been no agreement on specific issues such as the management of financial pressures and the extent to which financial risks will be shared with the commissioners. The absence of a service level agreement compounds the confusion.

PERFORMANCE MANAGEMENT AND ARRANGEMENTS TO MONITOR SERVICES

Joint commissioners

6.27 Standards have been developed as part of the contract for older age services at Monet Lodge with Anchor Trust. As stated earlier however, there is no service level agreement in existence between the care trust and commissioners and CHI was unable to find evidence of standards of care that had been agreed by all partner organisations. There is no comprehensive performance management framework to provide the trust with clear targets and the commissioners with a robust means of monitoring the quality of services. Finance and activity are monitored but there is no quarterly formal assessment of performance. The JCT relies mainly on incident reporting, CHC reports and the work of the scrutiny committee for information about the quality of services.

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Chapter 6 *continued*

Manchester Health Authority and Greater Manchester Strategic Health Authority

6.28 CHI found little evidence of standards agreed between Manchester Health Authority and the mental health partnership to enable monitoring of older age mental health services. In addition, the health authority did not have an established quality review process. Although there was monitoring of corporate responsibilities through an accountability agreement, there was little formal monitoring of services. The role of the joint monitoring committee was to review the arrangements but it did not monitor the quality of services.

6.29 The Greater Manchester Strategic Health Authority began working in April 2002 and was formally established as a strategic organisation in October 2002. The responsibilities of the PCTs and the strategic health authority for trust performance management and quality monitoring are not clear. There is confusion about lines of accountability between the JCT, JCE, PCTs, the local authority and the strategic health authority. The strategic health authority comments that operational management issues are devolved to the PCTs and that it is commencing health community wide performance reviews as part of the Greater Manchester Strategic Health Authority strategy.

6.30 Concentration on access times and activity targets in the acute sector led to a lack of focus on mental health including older age services. Performance management of clinical governance focused primarily on CHI reviews, action plans, clinical governance development plans and implementing the electronic reporting system, which includes serious incidents. In respect of the trust, the main focus of the strategic health authority was the electronic reporting system. A forum for medical directors across Greater Manchester was recently created to help develop clinical leadership. The strategic health authority has also established a bimonthly clinical governance forum for all trust clinical governance leads but nobody from the trust has been able to attend yet. The strategic health authority points out that the trust chief executive has been involved in the chief executives' forum and one to one meetings with the authority's chief executive.

6.31 CHI is concerned that Manchester Health Authority and subsequently the strategic health authority were reluctant to intervene and assume overall responsibility for the strategic direction, performance management and quality assurance of mental health services and the significant risk factors within mental health. The deteriorating financial situation and breakdown in relationships have been apparent for some time. The strategic health authority commissioned an independent management consultant to review the financial problems and the robustness of the financial recovery plan. The review concluded that the recovery plan was as robust as could be expected but commented that the financial crisis was symptomatic of the lack of strategic management capacity at the trust, the difficulty in modernising services and the poor relationships between commissioners and the trust. The strategic health authority has now begun to develop a strategic framework for mental health services and establish a baseline for older age services.

NHS north west regional office and Directorate of Health and Social Care – North

6.32 Until October 2002, the NHS north west regional office and, subsequently, the DHSC – North were responsible for the performance management of individual trusts within the NHS against national standards, and for taking forward the modernisation agenda. They reported, however, that they had no role in performance managing individual services within individual trusts and couldn't provide CHI with any information on the trust. They commented that the role of both the DHSC and its predecessor was to performance manage the NHS to meet Government objectives and targets for improving healthcare delivery. It is clear that performance management at the DHSC and the regional office gave priority to monitoring access targets for waiting times in acute services.

6.33 As mentioned previously, the regional office had a role in scrutinising the application to become a care trust.

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Chapter 6 *continued*

KEY FINDINGS

1. There is no agreed vision for mental health services for older people to which all the key partners are committed. These services are not a priority and the local delivery plan does not contain references to them. The strategic health authority recently took steps to gain agreement on a strategic direction for mental health services and to establish an older people's network.
2. The key planning document for the health community, the local delivery plan, does not contain any references to older age mental health services.
3. Commissioning arrangements are complex and there are confused lines of accountability between the JCT, PCTs, local authority and the strategic health authority. This was also the case in the time of the health authority, north west regional office, and DHSC. This is particularly evident for responsibility for quality assurance of services.
4. There are poor working relationships between the trust and its commissioners. The trust also has significant financial problems.
5. There is no comprehensive performance management framework or service level agreement to provide the trust with clear targets and the commissioners with a robust means of monitoring the quality of services. Nobody is monitoring quality other than via complaints and incidents.
6. The organisational arrangements to deliver and monitor the NSFs that relate to this client group, and responsibility and accountability for these, are confused.
7. The assessment that the partnership was fit to become a care trust appears to have been flawed. The process for screening care trust applications was hampered by the delay in establishing the criteria. Considering the definitive criteria, it is difficult to see that the Manchester application would have withstood robust scrutiny.
8. The complexities of forming a care trust diverted management time from improving the quality of services. There is no evidence as yet that becoming a care trust has improved joint working or outcomes for older age patients.

RECOMMENDATIONS

1. There is an urgent need to improve working relationships between the care trust and commissioners and to develop an agreed strategic vision and models of care. The partners need to work together to transform and modernise the service for patients. Interdependence needs to be recognised and a common agenda agreed.
2. The boundaries of responsibility need to be clarified. The Department of Health should review the complex accountability arrangements for the quality of care in health and social care trusts. Individual organisations should also be clear about their responsibilities to patients and for patient safety.
3. A robust performance management framework needs to be agreed and used within the trust as part of a service level agreement, so that commissioners can also monitor the quality of care.
4. The strategic health authority needs to build on recent work to lead the health community towards the development of transparent and effective organisational arrangements to deliver the NSFs relevant to older people with mental health problems.
5. The Department of Health should evaluate the process for the consideration of applications for care trust status.

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Chapter 7

Strategic capacity

7.1 The mental health partnership and subsequently, the trust have experienced rapid organisational change. The trust has complex external relationships and the boundaries of responsibility are unclear. There are significant financial problems. There are also internal challenges with multiple information systems and communication problems with staff on multiple sites. The agenda to modernise services is daunting given the current baseline and scale of change required.

7.2 Because the mental health partnership was formally a sub committee of the health authority, circulars that were sent by the Department of Health to NHS trusts did not automatically go to the partnership. This, on occasion, disadvantaged the organisation since it meant a delay in receiving policy and guidance, and hindered timely bids for available funding. However, when the partnership was part of the health authority and not a trust, it was not always eligible for funding streams.

STRUCTURES AND ACCOUNTABILITIES

7.3 At the time the mental health partnership was established there was a decision to keep management costs low; a management cost target was set and achieved. There is an appreciation now within the trust that there is insufficient management capacity to deliver its agenda.

7.4 The trust board consists of the chair, chief executive, non executive directors, five executive directors and an associate director. Two of the non executive directors are city councillors. There are directors for the two client groups, adult and older age, a director of finance and information management and technology (IM&T), a director of service development and a director of service governance. The director of adult services is also director of nursing and the director of service governance is also the medical director. The associate director post is new and is responsible for HR. The director of older age services had responsibility for HR from March 2001 until November 2002. The director of older age services left the trust in June 2003 to take up a new appointment in a local authority.

7.5 The executive directors carry extensive portfolios and have limited management support. It is not clear where overall responsibility lies for clinical priorities. The capacity problem in HR has been outlined in chapter 5. The management infrastructure for clinical governance is also inadequate (see chapter 4). The overall lack of management capacity is a serious concern. The interrelationships and accountabilities between committees are not always clear, for example, between the service governance committee, the original risk management group, the new risk management committee and the scrutiny committee.

7.6 The portfolio of the combined director of adult services and director of nursing is another cause for concern as both roles carry a heavy workload and are critically important. The situation is exacerbated because there is little senior clinical nursing support in older age services. Reference has been made in chapter 5 to the slow progress of the development agenda for nursing in older age services. These services are outdated and staff seem unaware of advances in care. Many nurses in older age services do not know the identity of the director of nursing.

7.7 Medical leadership comes from the medical director and the lead consultant for each directorate. The lead consultant for older age services covered working age adult services for a period but the trust states there is now a lead for working age adults in each locality. The lead consultant role differs from that of clinical director, of which there are none in the trust. The role does not involve holding a budget but includes advising the service director on operational issues such as the medical staff and drugs budgets. The lead consultant for older age services is also the associate medical director for medical staffing issues. The role involves representing medical staff at the governance committee and professional leads meeting. The lead consultant is accountable

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 7 *continued*

to the medical director on performance and disciplinary issues, however, CHI is unclear how the role of the lead consultant fits with the wider aspects of clinical governance and its leadership in the directorate. There are associate medical directors for medical education and for research and development.

7.8 The lead consultant for older age services does not have regular meetings with the medical director. In older age services monthly consultant meetings are held primarily to deal with operational issues and to troubleshoot on service delivery. The lead clinicians from different professional groups have not met for some time. Medical accountabilities and relationships are complex as many staff have university appointments, different visions of the service and strong locality ties.

7.9 Some trust staff expressed uncertainty about lines of professional and management accountability in the trust, particularly among allied health professionals who have professional heads of services, professional leads and line management accountability to locality managers. The medical director chairs the professional leads committee and on occasion represents the concerns of other professional groups at board level. He is responsible for the professional development of all of these staff groups. The director of nursing represents nurses at the board. Allied health professionals have no formal representation other than via the medical director.

7.10 CHI has concerns about the management capacity at middle management level. The trust introduced flat management structures without developing clinical and managerial leadership of ward managers. In particular, there is a capacity problem and weakness in management in the older age directorate. There are ward managers, three locality managers and an inpatient manager, all directly accountable to the director of older age services. There are also professional leads for psychiatry, psychology, nursing and occupational therapy. At one stage there was a directorate manager post but this was removed when the post holder left in June 2002. The inpatient manager is responsible for the management of all inpatient wards since the transfer of Rowan ward patients to Wythenshawe Hospital.

7.11 The re-provision of services for patients with challenging behaviour and needing continuing care, posed particular problems in south Manchester. On Rowan ward there have been successive ward managers in post since the summer of 2001, most in a temporary capacity. Problems identified by nursing staff were not resolved by middle management or adequately drawn to the attention of the director. Staff told CHI that management neglected the ward and that they were unheard. Some senior staff are described as unapproachable and the culture as closed and inward looking. This can be linked to earlier comments on the failure to develop nursing staff and achieve effective multidisciplinary teams.

DIRECTION AND PLANNING

7.12 The trust board was established in April 2002, although not all non executive appointments were confirmed at that time. Much of the board's first year agenda and management time have centred on serious financial problems and the consequences of the Rowan ward allegations. The board has little input to clinical governance or the development and implementation of performance management. CHI is concerned about the extent to which non executives see service/clinical governance as part of their role and take responsibility for the quality of services, challenging their executive colleagues where necessary. One of the non executives has lead responsibility for older age services. This role does not yet encompass any monitoring responsibility for the quality of services or the National Service Framework (NSF) for Older People.

7.13 There is a clear consensus among partners and stakeholders that the trust does not have sufficient strategic leadership to work with internal clinicians and health and local authority partners to deliver the transformation of services necessary to improve the quality of care. Relationships with the commissioners are

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 7 *continued*

dysfunctional, there are no service level agreements in place and there is a significant financial deficit. There is no clear sense of direction and a lack of purpose and identity. The board avoids confrontations and fails to act decisively in the face of union or service user/carer group opposition; there is a reactive approach to problems.

7.14 There is a widespread perception outside the trust that visionary clinicians need to be at the heart of decision making and that the current model of clinical leadership and clinical engagement is not working, despite the best efforts of individuals. CHI was told about a general failure within the trust to engage clinicians, particularly doctors, to engender change.

7.15 Contrary to what would be expected in a care trust, there is little evidence of progressive practice in most older age services and models of care are outdated. Professional boundaries are protected; there is less joint training than would be expected and no synergy of medical and social models. There has been little integration of social care and health staff. The care trust has been troubled since its inception and has not taken the leap into integrated work practices.

7.16 Many systems are either not in place or do not work properly. There is relatively little turnover of management staff at all levels, which has inhibited the introduction of new ideas. Generally there is a reluctance to lead the process of change.

7.17 There is a very limited performance management framework within the trust. Its focus has been mainly on finance and activity, and an analysis of complaints and serious incidents. There is little confidence in the accuracy of information generated within the trust. There has been no systematic monitoring of progress on delivering the NSFs. Audit results are not considered by the board. The trust has provided details of a 2002/2007 development plan that was presented to the board in February 2003, and a service plan for 2002/2004. The objectives in the plan are not dated.

7.18 Information systems are not integrated in the trust; for example, there are still three separate patient administration systems. Some staff report a lack of IT skills and little progress towards e-learning. The software system for the care programme approach was designed in central Manchester and is proving difficult to roll out to other areas. Confidence in the accuracy of data generated centrally is low. There is little centralised HR information. When information is provided to the trust board, it is seldom questioned or challenged.

COMMUNICATION AND CULTURE

7.19 CHI was told many times that the care trust is like three trusts linked together and that it does not feel or function like one organisation. Some staff report that cross site links are being put in place and procedures unified, but others said the localities are still largely operating in isolation. There are examples of good practice that haven't yet been rolled out from one locality to another, such as evidence based drug use in north Manchester. There is also a culture of resistance to change.

7.20 The three localities have different cultures that have been referred to earlier, particularly the different degrees of multidisciplinary working. Other differences include contracts of employment, clinical supervision, training and the implementation of the care programme approach. Some staff groups such as occupational therapists have worked together well across the three sites. However, there are few opportunities for staff to meet their colleagues from other parts of the trust.

7.21 There is also a divide between the trust's working age adult mental health services and older age services. Many staff in older age services perceive that general psychiatry has a higher profile and that older age services are disadvantaged within the trust. For some, the abandonment of Rowan ward on the Withington site is seen as evidence that older age services are not valued. There is much concern over the departure of the director of older age services. The trust, however, highlights that older age services have not suffered the same financial pressures as adult services.

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Chapter 7 *continued*

7.22 The trust has not successfully addressed the challenge of developing effective communication with staff who operate from a multiplicity of sites. Staff do not consider themselves well informed about what is happening in the trust. Only a quarter of staff in the 2002 survey thought that communication was good and that they knew what was going on; 32% thought staff views were listened to. Some staff had no knowledge of CHI's investigation, although the trust reports they communicated the visit extensively. The staff newsletter is appreciated but is bimonthly and notes from the board are perceived as being out of date. The website also needs updating and there is no trust intranet for staff to access. There is a view that successes are not adequately celebrated. There are also concerns about the absence of mechanisms for staff to feed back to management. The trust has recently developed a communication strategy and a team briefing system is to be implemented.

7.23 Some staff describe the organisation as being very stressful and pressurised.

KEY FINDINGS

1. The care trust has complex external relationships and the boundaries of responsibility are unclear.
2. The trust lacks strategic vision and strong leadership, both managerial and clinical. There is a serious lack of management capacity at every level. The board has little input to clinical governance and has not been involved in effective performance management.
3. Directors have extensive portfolios without adequate support. Individual responsibilities for quality of care and clinical governance are not clear. This is exacerbated by the lack of clarity over the relationship and accountabilities of committees, particularly in respect of risk.
4. The current model of clinical leadership and engagement is not working. Accountability arrangements for professional groups are confusing.
5. Many of the trust's systems are not in place or do not yet work properly.
6. Different cultures persist within the trust and there has been slow progress with harmonisation of policies. Localities within the trust work largely in isolation.
7. Older age services are not progressive. Staff in older age services feel these services have low priority.
8. The trust has not yet succeeded in communicating effectively with staff working on multiple sites and staff do not feel well informed about what is happening in the trust.

RECOMMENDATIONS

1. The boundaries of responsibility need to be clarified. The Department of Health should review the complex accountability arrangements.
2. There is an urgent need to strengthen management capacity and leadership at every level in the trust. The organisation needs to develop a positive 'can do' approach, moulding and influencing events rather than reacting to them.
3. Executive capacity in clinical matters must be enhanced and directors' portfolios need reviewing.
4. Professional and managerial accountabilities need to be clearly specified and robust performance management developed.
5. There must be a clear hierarchy of committees and understanding of the process whereby key decisions are taken.
6. Clinical governance systems need to improve.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Chapter 7 *continued*

7. Communication to staff must improve. The trust needs to engender a sense of vision, unity, common culture, direction and purpose, while maintaining local identities.
8. Commitment to older age services needs to be demonstrated.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix A

Terms of reference for the CHI investigation into the care of older people with severe mental impairment by Manchester Mental Health & Social Care Trust

1. In October 2002, following concerns raised by Manchester Mental Health & Social Care Trust through Greater Manchester Strategic Health Authority, the Commission for Health Improvement (CHI) was made aware of allegations of serious abuse of older people with severe mental impairment at Rowan ward, Manchester Mental Health & Social Care Trust. Greater Manchester Strategic Health Authority requested CHI's intervention.
2. In November 2002 CHI decided to undertake an investigation into the care of older people with severe mental impairment, including Rowan ward, Manchester Mental Health & Social Care Trust.
3. The investigation will focus on the care of older people with severe mental impairment by Manchester Health & Social Care Trust (and its predecessor organisations), to establish whether the trust has maintained appropriate standards in the management, provision and quality of care. The investigation will consider:
 - i) An examination of the systems and processes that ensure the quality and model of care for older people with severe mental impairment, including
 - a) assessment and planning for individualised care including the need for specialist input
 - b) the role of service users, carers and advocates, including access to independent advocacy for service users and/or carers, in care planning
 - c) consent
 - d) record keeping and monitoring of care plans
 - e) the environment in which care has been and is currently provided
 - f) the culture and philosophy underpinning the care provided on Rowan ward
 - g) the suitability of the care provided on Rowan ward including an evaluation of the assessment and understanding of the needs of patients by staff. This will include an evaluation of how well professionals working on Rowan ward understand the interaction of old age, frailty, cognitive impairment and functional mental illness, and how needs and risks relating to these factors are assessed
 - h) the impact on the quality of the care of older people with severe mental impairment on Rowan ward, as a result of the transfer of mental health services from Withington Hospital
 - i) the implementation, adequacy and monitoring of relevant policies and procedures including risk management, protection of vulnerable adults, control and restraint, the care programme approach, and health and safety. This will include an examination of the scope, quality and use of the local multiagency code of practice for preventing and tackling abuse based on the Department of Health's *No Secrets* national framework
 - ii) An examination of management and staffing issues relevant to Rowan ward including:
 - a) staffing levels, including skill mix
 - b) the recruitment and retention of staff

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix A *continued*

- c) the use of agency and bank staff
 - d) supervision, appraisal, training, personal and professional development
 - e) teamworking and communication
 - f) managerial and clinical leadership
 - g) management structures and accountabilities
 - h) the adequacy, implementation and monitoring of HR policies and procedures including whistle blowing, grievance and disciplinary, bullying and harassment
- iii) The performance management, quality monitoring and clinical governance arrangements, including clinical audit, for services for older people with severe mental impairment at the trust, including:
- a) the internal arrangements within the trust. This will include an examination of the management and focus of, and the action following:
 - internal inquiries and/or external reviews
 - complaints either by patients, relatives, staff or organisations representing patients, relatives or staff
 - incident reporting and investigation including awareness and understanding of staff of incident reporting
 - audit, effectiveness, learning, research including academic links, dissemination and evaluation
 - whistleblowing
 - b) the commissioning and performance management role conducted by the Manchester mental health joint commissioning team (and its predecessor organisations)
 - c) the performance management and quality monitoring role conducted by Greater Manchester Strategic Health Authority (and its predecessor organisations)
 - d) the performance management and quality monitoring role conducted by the Directorate of Health and Social Care – North (and its predecessor organisations)
- (iv) The views of those using services, if appropriate, their relatives, friends, advocates, organisations representing service users and any other individual or organisation wishing to express views to CHI about the quality of services for older people with mental health problems provided by Manchester Mental Health & Social Care Trust (and its predecessor organisations)
- (v) Any other matters arising during the investigation which CHI considers to be relevant to reaching their conclusions on the management, quality and provision of healthcare to older people with severe mental impairment by the trust

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix A *continued*

Additional information

4. The investigation will be conducted by CHI under powers set out in section 20(1)(c) of the Health Act 1999. This empowers CHI to investigate, and make reports on, the management, provision and quality of healthcare. CHI's purpose in investigating a trust or other NHS organisation is to help that organisation to improve the quality of the healthcare it provides, build or restore public confidence in the services provided and to help the organisation and the wider NHS to learn lessons about how best to ensure patient safety.

5. CHI will publish a report on the findings of the investigation and will make recommendations as appropriate to the trust and other relevant bodies.

6. Where recommendations are made, CHI will provide advice and assistance to all relevant organisations towards the preparation of an agreed action plan for implementation. Overseeing the implementation of an action plan prepared by the trust will be the responsibility of Greater Manchester Strategic Health Authority.

7. CHI will ensure effective collaboration, as required, with other organisations including Greater Manchester Police.

20 January 2003

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix B

Documents received in the course of the investigation

A summary of the documents received by CHI while conducting the investigation is given below. A full list of the documents is available on CHI's website or upon request. CHI received over 1,600 documents. The majority were received from and related to:

- Manchester Mental Health Partnership and Manchester Mental Health & Social Care Trust
- South Manchester University Hospitals NHS Trust
- the joint commissioning executive and team
- Manchester Health Authority and Greater Manchester Strategic Health Authority
- South Manchester Community Health Council

The type of documents received from each of the above organisations is detailed below.

MANCHESTER MENTAL HEALTH PARTNERSHIP AND MANCHESTER MENTAL HEALTH & SOCIAL CARE TRUST

- details/profile of the trust and its services
- minutes and some supporting papers from trust committee and group meetings. These include board, directorate, executive management team and service governance committees and groups that report to the governance committee
- clinical/service governance reports and development plans
- risk management policies, procedures and reports
- documents related to the care programme approach including policies, procedures and related training and audit
- clinical audit results, plans and other associated documents
- dementia care mapping documents
- education and training policies, procedures and reports
- staffing policies, procedures and reports
- staff newsletters
- user group meetings, newsletters and surveys
- clinical, operational and service policies, procedures and reports
- service plans, consultations and agreements including care trust application and joint reviews
- national service framework information and plans
- the organisation's responses and actions following external reports from the Mental Health Act Commission, the Health and Safety Executive and the nurses from Pennine Care NHS Trust
- documents relating to actions following internal reports

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Appendix B *continued*

- information related to the relocation of Rowan ward services
- documents related to the trust's internal investigation and review

SOUTH MANCHESTER UNIVERSITY HOSPITAL TRUST

- details/profile of the trust and its services
- minutes and related information from trust committee and group meetings, including board, directorate and clinical audit groups
- risk management policies, procedures and reports
- documents related to the care programme approach including policies, procedures and related training and audit
- clinical audit results, plans and other associated documents
- education and training policies, procedures and reports
- staffing policies, procedures and reports
- user group meetings, newsletters and surveys
- clinical, operational and service policies, procedures and reports
- service plans, consultations and agreements
- the organisation's responses and actions following external reports
- information related to the relocation of Rowan ward services

THE JOINT COMMISSIONING EXECUTIVE AND TEAM

- minutes and related information from commissioning committee and group meetings, including meetings and stakeholder groups held in relation to Rowan ward services
- risk management policies, procedures, reports and related correspondence
- service plans, consultations and agreements including joint reviews
- national service framework information and plans
- information related to the relocation of Rowan ward services

MANCHESTER HEALTH AUTHORITY AND GREATER MANCHESTER STRATEGIC HEALTH AUTHORITY

- board minutes
- service plans, consultations and agreements including accountability agreements
- national service framework information and related monitoring documents
- information related to the relocation of Rowan ward services

SOUTH MANCHESTER COMMUNITY HEALTH COUNCIL

- user group meetings and newsletters
- reports of site visits
- details of complaints and correspondence with the trust
- information related to the relocation of Rowan ward services

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix B *continued*

CHI also received or obtained a number of other documents from other organisations, including those listed below. These documents are summarised by document type.

- risk management policies produced by Manchester Social Services
- education and training documents and information produced by the Manchester health community, primary care trusts, City College in Manchester and the North West Health Care Libraries Unit
- clinical and operational policies produced by primary care trusts, Manchester Health Authority and the Admiral Nurses
- external reports conducted by the Mental Health Act Commission, District Audit, an independent management consultant, North West Regional Access Team, nurses from Pennine Care NHS Trust, the clinical negligence scheme for trusts, the Health and Safety Executive and the Royal College of Psychiatrists, as well as externally commissioned reports related to the reprovision of Rowan ward services
- national guidance/reference documents produced by the Department of Health, Manchester MIND, the Nursing and Midwifery Council, the Salisbury Centre for Mental Health, the Centre for Suicide Prevention and the NHS Executive
- press cuttings
- documents and related information regarding the application to become a care trust supplied by the Directorate of Health and Social Care – North, the Department of Health, Manchester Health Authority and Manchester City Council

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Appendix C

Interviews conducted

CHI conducted a total of 142 interviews. The following shows a breakdown of those interviewed:

TRUST STAFF

Chief executive and executive directors	.6
Chair and non executive directors	.3
Non clinical senior and middle managers	.11
Clinical middle managers	.3
Ward managers and assistant ward managers *	.10
Consultant psychiatrists	.6
Consultant psychologists	.2
Junior and other doctors	.5
Qualified nurses *	.21
Nursing assistants *	.18
Allied health professionals	.5
Domestic staff	.4
Staff side/trade unions	.2

* including members of bank and agency staff and night staff

OTHER

Community Health Council	.3
Directorate of Health and Social Care	.4
Department of Health and regional office	.1
Joint commissioning team	.2
Primary care trusts	.4
Pennine Care NHS Trust	.2
Strategic health authorities	.9
South Manchester University Hospitals NHS Trust	.1
Social services	.5
Social Services Inspectorate	.1
Other	.6

RELATIVES, THE PUBLIC AND VOLUNTARY ORGANISATIONS

(see also appendix D for a summary of relatives' and public views)

Sets of relatives	.5
Relatives group meeting	.1 meeting with 15 relatives
Age Concern	.1
Alzheimer's Society	.1

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Appendix D

Summary of views from relatives and the public

METHOD OF OBTAINING VIEWS

CHI sought to obtain views from patients' relatives and the public about services for older people with mental health problems and, in particular, views about Rowan ward and the Monet wing of Cavendish ward.

The investigation was announced in December 2002. During January and February 2003 information was distributed to stakeholders, voluntary organisations and community groups. This included posters advertising times when stakeholders could come and talk to CHI, and information leaflets about the investigation. We translated the information into eight languages. We explained that comments were welcome face to face and by telephone, email or letter. Press releases were issued to local newspapers and radio stations.

Twenty six organisations received leaflets about the stakeholder events.

RESPONSE RATE

As a result of the publicity CHI met five sets of relatives in face to face interviews during March 2002 and talked to two more on the telephone. We also met with representatives of South Manchester Community Health Council (CHC) and the local branches of the Alzheimer's Society and Age Concern.

During the site visit in April 2003, members of the investigation team met with the Healey House relatives' support group. The group includes 15 relatives, the CHC and a representative of the older peoples advocacy service.

ISSUES RAISED

There was a high level of agreement about the main issues. These can best be divided into before and after the allegations.

Before the allegations

Worry about the isolation of Rowan ward

Once the majority of services moved from the Withington site in August 2001, Rowan ward became increasingly isolated and the external environment deteriorated. The relatives and the CHC were concerned about this and the lack of security on the site.

Concerns about care prior to the allegations

Most relatives were generally satisfied with care provided. There were few recorded complaints. Two people contacted CHI to state that they felt their relative had had exemplary care during their time on the ward in 2000. Others felt reasonably satisfied at the time, but now look back and feel they should have queried staff explanations of bruising and weight loss. Some are concerned that staff told them that weight loss was a symptom of dementia, but since the patients have moved to Monet wing, some who had previously lost weight have regained it. There were two complaints involving injuries and delay in obtaining treatment. Concerns were also raised with CHI about the lack of staff awareness and sensitivity to diversity issues and cultural differences. Relatives report they had little input into care plans and that there were few activities for patients.

Staffing levels

CHI heard mixed views about the adequacy of staffing numbers. All agree there had been many temporary staff. Some report there were too few staff to help feed patients or organise activities, others feel the numbers were sufficient but there may have been a lack of training and supervision.

Concerns for the future

Families were concerned about the future provision of Rowan ward and what it would mean for their relatives. There was some anxiety that alternative provision might have to be found for individuals and that they received conflicting information from different people.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix D *continued*

After the allegations

Communication

Many relatives feel dissatisfied with how the trust has communicated with them. They cite the manner in which they were initially told about the allegations, which they consider was insensitive.

The relatives support group states that it has been very difficult to get answers from the trust and that the explanations of events from different staff is often inconsistent.

There have been a few instances where families have not been happy with information about their relative.

Attitude of trust

Relatives point out that the strategic health authority's medical director was the first person to apologise to them for the distress they experienced. They were upset that in the first few weeks after the allegations were made a number of different people from the trust came to speak to the support group.

Some responses from the trust to complaints were considered to be poorly expressed and insensitive.

Standards of care

Most relatives accept that care has improved since the move to Monet wing. They have been more involved in care planning since the move. They are, however, concerned that the lack of space restricts the activities in which patients can participate.

ONGOING INVOLVEMENT

The relatives' support group continues to meet and is actively involved in planning the move to Monet Lodge. They are worried about the continuing delay.

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Appendix E

Glossary

TERM	EXPLANATION
acute <i>care/ trust/hospital</i>	short term (as opposed to chronic, which means long term). <i>Acute care</i> refers to medical and surgical treatment involving doctors and other clinical staff in a hospital setting. <i>Acute hospital</i> refers to a hospital that provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.
Admiral Nursing service	Admiral Nurses provide specialist knowledge, advice and training about dementia care to other professional carers and support informal carers such as family and friends.
adverse incident	something that has happened that is out of the ordinary and unintended which may be harmful to patients. For example, a patient falling on an icy path, or not receiving a meal when they needed one.
advocacy/advocate	a scheme, which represents individual patient views or concerns. An advocate is a person unrelated to a patient who can speak on their behalf and make a case for their welfare.
adult services	mental health services provided to people between the ages of 18 and 65.
agency staff	staff who are supplied by an agency, which the organisation pays for, to cover where there is a lack of personnel.
allied health professionals	professionals regulated by the Council for Professions Supplementary to Medicine (new Health Professions Council). This includes professions working in health, social care, education, housing and other sectors. The professions are art, music and drama therapists, prosthetists and orthotists, dietitians, orthoptists, occupational therapists, physiotherapists, biomedical scientists, speech and language therapists, radiographers, chiropodists and podiatrists, ambulance workers and clinical scientists. Also called professionals allied to or supplementary to medicine.
Alzheimer's disease	Alzheimer's disease is the most common form of dementia, affecting around 500,000 people in the UK. It is a progressive disease caused by a shortage of certain chemicals in the brain.
Anchor Trust	Anchor Trust is a not for profit organisation, dedicated to helping older people to live safely, securely and independently with a choice of services to suit all needs.
appraisal	the assessment, at regular intervals, of an employee's performance at work.
cardiopulmonary resuscitation (CPR)	the technical term for resuscitating a patient who has collapsed (usually unconscious) in which the underlying cause is severe illness with circulatory or breathing failure.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix E *continued*

care plans	a comprehensive plan for the care of a resident, developed by a multidisciplinary team including family members, nurses, dieticians, doctors, therapists, and social services professionals. The plan spells out the type of care to be provided, with stipulated timeframes for completion and assignment of responsibilities to specific staff.
care programme approach (CPA)	the system used to ensure that people with severe mental illness receive the care they need. Service users on CPA will have a written care plan and will have a key worker as their main point of contact with services.
carers	people who look after their relatives and friends on an unpaid, voluntary basis often in place of paid care workers.
care trust	a new type of NHS body which combines NHS healthcare services and certain delegated functions from local authorities, including personal social services.
challenging behaviour	behaviour that includes being, at times, unpredictable, antisocial, disinhibited, lacking insight, unaware of danger, emotional, with repetitive habits or aggressive.
CHI	see Commission for Health Improvement
clinical	any treatment provided by a healthcare professional. This will include, doctors, nurses, AHPs etc. Non clinical relates to management, administration, catering, portering etc.
clinical audit	the continual evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service. Standards can be set by health professionals themselves, or others. Successful clinical audit also involves changing practice to meet the standards.
clinical director	the clinician (often a doctor) who is accountable for clinical and sometimes management elements of service delivery.
clinical effectiveness	for individuals, the degree to which a treatment achieves the health improvement for a patient that it is designed to achieve. For whole organisations, the degree to which the organisation is ensuring that 'best practice' is used whenever possible.
clinical governance	refers to the quality of healthcare offered within an organisation. The Department of Health document <i>A First Class Service</i> defines clinical governance as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." It's about making sure that health services have systems in place to provide patients with high standards of care.

Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust

Appendix E *continued*

clinical incident	something (usually an error) that occurs in a hospital or in the community where actual or potential harm may have been experienced by patients or the public.
clinical negligence scheme for trusts (CNST)	an insurance scheme for assessing a trust's arrangements to minimise clinical risk, which can offset costs of insurance against claims of negligence. Successfully gaining CNST standards (to level one, two, three) reduces the premium that the trust must pay.
clinical psychologists	trained professionals who work to promote mental well being. Clinical psychologists work with people with mental health problems, eg anxiety or depression, and those with physical illnesses.
clinical supervision	clinical supervision brings practitioners and supervisors together to reflect on practice. It is not a managerial control system, although links are important. Its aim is to maintain and promote standards of care.
clinician/clinical staff	a fully trained health and qualified professional – doctor, nurse, therapist, technician etc.
cognitive impairment	a loss or deterioration of mental capacity. A deficiency in a person's short or long term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment. Typically related to an illness or injury, like Alzheimer's disease, stroke, or traumatic brain injury.
Commission for Health Improvement (CHI)	independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.
commissioning	identifying the needs of the population and then planning and purchasing the required services to meet those needs.
community health council (CHC)	a statutory body sometimes referred to as the patients' friend. CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.
community mental health team (CMHT)	a team of mental health professionals that undertake assessment and monitoring of mental health needs via the care programme approach and care management in a community setting.
community psychiatrist	see psychiatrist – a community psychiatrist works with service users in a community setting.
consent	permission, from a patient or sometimes a patient's nearest relative, to allow a health treatment or investigation to happen.
consultant	a fully trained specialist in a branch of medicine who accepts total responsibility for specialist patient care. (For information on the training and staff grade posts of doctors, see doctors).
continuing care	a long period of treatment for patients whose recovery will be limited.
continuing personal and professional development	to keep up to date with developments in a particular field of work and take part in activities to broaden and enhance personal qualities and skills.

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Appendix E *continued*

control and restraint	a method of responding to the challenging behaviour of people with learning disabilities that involves some degree of physical force that limits or restricts the movements or mobility of the person concerned.
covert medication	the administration of medication without the knowledge or consent of the patient.
CPR	see cardiopulmonary resuscitation
Criminal Records Bureau	the Criminal Records Bureau enables organisations to gain access to important criminal and other information for recruitment and licensing purposes. It helps organisations to perform better by screening out candidates who may be unsuitable for certain kinds of work. In doing this it particularly helps to provide protection for children and other vulnerable members of society.
Crown Prosecution Service	The Crown Prosecution Service is responsible for prosecuting people in England and Wales charged by the police with a criminal offence.
dementia	This term describes a group of symptoms that encompass a loss of intellectual ability, mental processes, vocabulary, abstract thinking, judgment, memory loss, and physical coordination that interfere with daily activities. The symptoms can be brought on by degenerative diseases like Alzheimer's, Huntington's and Parkinson's diseases, vascular diseases, stroke, metabolic disorders like thyroid, liver kidney dysfunction, certain vitamin deficiencies, AIDS, drugs and alcohol, or psychiatric disorders. Some dementia's may respond to treatment, others do not.
directorates for health and social care (DHSC)	Bodies set up in April 2002, responsible for overseeing the development of the NHS and social care in England. Their role involves assessing the performance of health and social care services, guiding senior NHS staff, improving public health and providing support to Government ministers. There were four DHSCs with responsibility for the following geographical areas: Midlands and the east; the north; the south; and London.
e-learning	training and learning through the use of the internet.
electroconvulsive therapy (ECT)	involves the application of electric shocks to the brain while the recipient is unconscious. Used in the treatment of severe mental illness although usage has declined in favour of other methods.
Essence of Care	sets out clear standards that nurses and other staff should meet, for example in ensuring that patients have the privacy and dignity on the wards or are given food of high nutritional value.
estates department	responsible for the maintenance and repair of all grounds and property owned by an NHS organisation.
evidence based	the systematic analysis of information on the effectiveness of treatment to provide the best care for patients.
financial recovery plan	the plan a trust enacts to bring them back into financial balance/offset a previous financial loss

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Appendix E *continued*

functional mental illness	mental illness that has no biological cause
general practitioner (GP)	a family doctor, usually patients' first point of contact with the health service.
health and safety	regulation of risks to health and safety arising in the workplace.
health authority (HA)	NHS body that was responsible until April 2002 in England for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities. The commissioning work of health authorities has now moved to primary care trusts.
Improving Working Lives	a Department of Health initiative launched in 1999. It includes standards for developing modern employment services, putting in place work/life balance schemes and involving and developing staff.
incident reporting system	a system which requires clinical staff to report all matters relating to patient care where there has been a special problem.
incidents	something that has happened that is out of the ordinary, and which may be harmful to patients.
induction	training and orientation provided for staff members new to an organisation or clinical area.
information management and technology (IM&T)	a term that encompasses the way an organisation manages its information using technology, ie the computer system for handling its information more effectively.
information technology (IT)	includes use and supply of all computer systems.
institutionalise	to subject to the harmful effects of confinement in an institution.
investigation – by CHI	an in depth examination of an organisation where a serious problem has been identified.
joint commissioning board/executive/team	an arrangement where local authority and primary care trusts bring their funds together to commission mental health and social care services. The executive act as the commissioners and the team implements the decisions made by the executive.
lay member	a person from outside the NHS who brings an independent voice to the work of CHI and others.
leading empowered organisations (LEO) programme	a three day training programme designed to equip health care professionals for leadership and to make changes in NHS organisations.
local implementation team	supports local stakeholders in the planning and implementation following the national service framework. They can assist PCTs in the development of local implementation plans and to support commissioning of mental health services appropriate for the areas they represent.
locum	a doctor who stands in for another.

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Appendix E *continued*

Manchester care assessment schedule (MANCAS)/MANCAS 65	this model was initially developed to help assessment of need. More recently, it has been extended to meet the specific needs of older people with mental health problems. The interview schedule uses a conceptual framework that places current needs within the context of an individual's life experience. Staff using this framework in Manchester's mental health and care services undergo a two day training programme and the schedule is being adopted as the city's baseline assessment and review protocol. Although stylised as an interview schedule, MANCAS is also used as an educational and training tool, with guidance on eliciting evidence of need and risk.
medical director	the term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical issues throughout the trust.
mental health trust	provide secondary care mental health service, and sometimes learning disability and substance misuse, usually from a combination of hospital and community locations.
Methicillin resistant staphylococcus aureus (MRSA)	a bacterium resistant to a wide range of antibiotics. If a patient is infected they can become seriously ill, or may die (this is more likely if the patient is already unwell).
multidisciplinary team	a group of people who are from different professional backgrounds concerned with the treatment and care of patients, who meet regularly to discuss patient treatment and care.
national service framework (NSF)	guidelines for the health service from the Department of Health on how to manage and treat specific conditions, or specific groups of patients eg coronary heart disease NSF, mental health NSF. Their implementation across the NHS is monitored by CHI.
national vocational qualifications	work related nationally recognised qualifications.
NHS regional office	offices that were responsible for the strategic management of the NHS and monitoring the performance of health authorities, trusts and primary care trusts in England. They were part of the Department of Health. Performance monitoring and strategic direction of the NHS is the function of strategic health authorities and the directorates for health and social care.
NHS trust	a self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc. Acute trust – provides medical and surgical services usually in hospital. Community trust – provides local health services, usually in the community, eg district nurses, chiropodists etc. Combined trust – community and acute trust services under one management. Primary care trust – new organisations that provide care usually available from a range of practitioners and their teams and commission services from various organisations.

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Appendix E *continued*

non executive director	director of an organisation or company who is not a full time staff member of that organisation or company, but is brought in to advise the other directors.
nursing director or chief nurse or chief nursing officer	the term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.
Nursing and Midwifery Council (NMC)	the Nursing and Midwifery Council is an organisation set up by Parliament to ensure nurses, midwives and health visitors provide high standards of care to their patients and clients.
occupational therapist	a trained professional (an allied health professional) who works with patients to assess and develop daily living skills and social skills.
older age services	older age services are predominately for people who are over 65 years of age. There may be cases, for instance in early onset dementia cases, when patients under 65 years of age are cared for by older age services, where these services are more appropriate.
organic mental illness	results directly from identifiable brain malfunction. May occur suddenly, eg brain damage caused by road traffic accidents, or over a prolonged period, eg senile dementia.
outcome	all the possible results that may occur from a treatment, service or prevention programme.
patient administration system (PAS)	a networked information system used in NHS trusts to record information about inpatient and outpatient activity.
patient advice and liaison service (PALS)	a service proposed in the July 2000 NHS plan due to be in place by 2002 to offer patients an avenue to seek advice or complain about their hospital care.
patient involvement	the amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.
performance management	using a review process (usually results delivered against objectives set) to assess how well a person, team or service is working.
person centred care	a system of care or treatment is organised around the needs of the individual.
primary care	family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

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Appendix E continued

primary care trusts (PCT)	<p>organisations that bring together all primary care practices in an area. PCTs are diverse and complex. Unlike PCGs, which came before them, they are independent NHS bodies with greater responsibilities and powers. Primary care trusts (PCTs) were introduced under the Health Act (1999) and established in successive (annual) waves. In response to the Department of Health's <i>Shifting the Balance of Power</i> they took over many health authority functions.</p> <p>PCTs are responsible for</p> <ul style="list-style-type: none">▪ improving the health of their population▪ integrating and developing primary care services▪ directly providing community health services▪ commissioning secondary care services <p>PCTs are increasingly working with other PCTs, local government partners, the voluntary sector, within clinical networks and with 'shared service organisations' in order to fulfil their roles.</p>
protocol	a policy or strategy, which defines appropriate action.
psychiatrist	a doctor who specialises in the diagnosis and treatment of mental health problems.
regional office	see NHS regional office above.
registered mental health nurse (RMN)	a nurse who is qualified to care for people with mental health problems and is registered with the English National Board for Nursing, Midwifery and Health Visiting.
rehabilitation	the treatment of residual illness or disability, which includes a whole range of exercise and therapies with the aim of increasing a patient's independence.
risk assessment	an examination of the risks associated with a particular service or procedure.
risk management	understanding the various risks involved and systematically taking steps to ensure that the risks are minimised.
risk register	a system for recording and monitoring untoward incidents and near miss incidents. It can be used to identify trends and reduce potential risks to clients and staff.
schizophrenia	a diagnosis given to some people who have severely disturbed beliefs and experiences. During an episode of schizophrenia, a person's experience and interpretation of the outside world is disturbed.
serious untoward incident (SUI)	an occurrence, which led, or may have led to harm in one or several patients which is of sufficient severity to warrant special investigation.
service audit	this is the term used to refer to clinical audit in some social care trusts. See clinical audit.
service governance	this is the term used to refer to clinical governance in some social care trusts. See clinical governance.

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service level agreements	formal agreements between different trusts and their primary care trusts about the amount and nature of services to be provided. For example, a trust may be contracted by a primary care trust to deliver 200 cataract operations or 70 hip replacements per year under a service agreement.
service users	people who use health and social care services for their mental health problems. They may be individuals who live in their own homes, are staying in care or are being cared for in hospital.
severe mental impairment	a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.
Social Service Inspectorate (SSI)	a government body that works independently or with other inspectorates to assess the performance of local councils, primarily social services departments.
stakeholders	a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation. In the case of hospital trusts, it includes patients, carers, staff, unions, voluntary organisations, community health councils, social services, health authorities, GPs, primary care groups and trusts in England, local health groups in Wales.
strategic health authority	organisations that replaced health authorities and some functions of Department of Health regional offices in April 2002. Unlike health authorities, they are not involved in commissioning services from the NHS. Instead they performance manage PCTs and NHS trusts and lead strategic developments in the NHS. Full details of the changes are in the Department of Health document, <i>Shifting the Balance of Power</i> , July 2001.
strategy	a long term plan for success.
terms of reference	the rules by which a committee or group does its work.
trust board	a group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.
vulnerable adults	people over the age of 18 who are or may be unable to take care of themselves or unable to protect themselves from abuse or exploitation.
whistle blowing	the act of informing a designated person in an organisation that patients are at risk (in the eyes of the person blowing the whistle). This also includes systems and processes that indirectly affect patient care.

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