Review of governance and management arrangements at Avon and Wiltshire Mental Health Partnership NHS Trust on behalf of NHS South of England

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25th January 2012

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Contents

		Page number
1	Executive summary	3
2	Background	6
3	Methodology	6
4	Context	6
5	Findings	
	Structures,	7
	Processes/procedures,	9
	Standards of care,	11
	People/culture,	13
	Communication/engagement	14
	Performance management/target setting	14
	Embedding learning/change	16
6	Conclusion	16
7	Recommendations	18

Appendices

Appendix 1 Terms of reference	20
Appendix 2 List of staff interviewed	21
Appendix 3 List of documents reviewed	22

Executive summary

- The Avon and Wiltshire Mental Health Partnership NHS Trust (AWP, 'the Trust') is an aspirant Foundation Trust and its formal application is at a stage where it is dependent on NHS South of England being assured that the organisation is fit to proceed.

- In November 2011, the NHS South of England Patient Safety and Care Standards Committee published two Mental Health Homicide Inquiry reports. Both investigations, relating to homicides in 2007, found direct causal links between the care and treatment of the two patients provided by the Trust and the homicides of the three individuals, and concluded that the deaths might have been prevented by better care and treatment of the patients.

- The Board of NHS South requested a review of the Trust governance and management arrangements in order to be assured that corporate and clinical governance arrangements, clinical leadership and wider stakeholder engagement are robust and patient safety assured.

- One of the largest mental health service providers in the country, the Trust provides adult mental health and related specialised services to a population of 1.6 million across a wide geographical area in Swindon, Wiltshire, Bristol, North Somerset and Gloucestershire.

- On taking up post in April 2006, the Chief Executive was faced with a disparate organisation which was failing to meet a number of required standards. She faced a difficult and challenging change agenda in order to address these issues as a matter of priority.

- Since then the Trust has been restructured from a locality based organisation to four and more recently five Strategic Business Units (SBU) based around the care delivery themes of secure and specialised, adult acute inpatients, drug and alcohol, liaison and later life, and adult acute community services. Each Business Unit provides services across the full geographic area of the Trust. Unusually leadership of each SBU is provided jointly by a Clinical Director who is accountable for the quality, safety and governance agenda and who reports to the Director of Nursing, Compliance, Assurance and Standards and a Service Director who is accountable for finance, performance and operational performance and who reports to the Director of Operations. Only one of the five clinical directors is a medical doctor and it is evident that there is a lack of medical engagement in the Trust at this level.

- The more recent change to split acute adult services into inpatients and community was seen as a top down decision made without clinical consultation and is not supported by a significant number of senior clinicians. The change does not appear to provide an optimal care pathway for patients and is indicative of the lack of clinical engagement in decision making.

- Over the same time (5years) the Trust has driven a number of redesign projects with varying degrees of successful completion and implementation. Nearly 18 months ago, the Trust embarked on another service redesign project which attempts to provide a single point of entry for patients, to deliver seamless care, reduce inpatient beds and deliver improved efficiency. Project implementation has been troubled by many factors, not least the complexities of consulting with multiple PCTs and local authorities and has been very protracted. This, coupled with the fact that the original Trust restructuring and some previous redesign projects are still not fully embedded, resonates markedly with the concerns

expressed in the MH Inquiry about the time taken to implement change and 'the detrimental effect on operational services'

- The Trust has clear risk management policies and processes in place. The Trust incident reporting system is paper-based although there are plans to introduce a new electronic system in March 2012. The Trust is one of the poorest performing in England for the speed of reporting incidents to the National Patient Safety Agency.

- The Trust has recently implemented an electronic patient information system – RIO. Almost without exception staff welcomed the move as it supports a huge improvement to patient care. There is however a concern that there are no plans to integrate the new incident system with the RIO clinical record system because of technical incompatibility.

- Taking into account the population served by the Trust (1.6 million), the expected incidence of suicide in the South West region based on 2008 National Confidential Inquiry data (10.1 per 100,000) and the proportion who will be mental health service users (26%), the expected rate of suicide of Trust service users would be around 45 per year, with 13% (n=5) being inpatients. The latest figures from the 2009 thematic review found that there were 41 incidents of suicide by Trust service users and seven suicides by inpatients (only one on the ward). This data is in line therefore with national averages.

- Reliable benchmarking data for homicides is not available, but raw data suggests that over the past 6 years the Trust has had a higher than average number of homicides committed by present or recent patients. Further analysis would be required to verify this, although learning lessons from individual homicide incidents remains crucial for any mental health trust.

- Performance management arrangements are comprehensively embedded and led by the Chief Executive through the executive team. However, performance management is very process driven, focussed to a very large extent on the delivery of targets, which are numerous and many of which are not clinically indicated.

- Internal communication is a mixed picture. There are some excellent examples of top down internal communication methods but little evidence of constructive dialogue and engagement of Trust staff in decision making.

- External communication appears to be less than optimal, senior Trust staff reporting very poor relationships with some commissioners and other stakeholders such as GPs.

- We observed the Trust culture to be centralist, top down, and target driven, bureaucratic and controlling.

- Significant progress has been made to put in place comprehensive, co-ordinated, Trust-wide governance structures and processes but nearly six years on from inception in its present guise the Trust is still beset with ongoing challenges relating to embedding high quality service delivery across all services.

- The focus from the Board and executive team is on process and demonstrating compliance both internally and externally at, we believe, the expense of integrating quality into clinical practice. There is a dominating emphasis on targets, many of which are of questionable clinical validity and which seem to have a negative impact on quality of care. Service delivery

is severely compromised in some clinical areas by the burden of key performance indicators in the Trust scorecards.

- Substantial work has gone in to meeting the recommendations of the homicide report action plans to improve services, in most part by implementing processes. However, taking Swindon as a barometer of the front line service, it is our view that those process improvements are not being disseminated, sustained and integrated into practice across all clinical services.

- There are many statements and conclusions in the MH/TC Inquiries that have resonance now. The MH review identified the services at the time of CJ's death as being seriously deficient. We have observed the Swindon services 5 years later to still be in a seriously deficient state and this is unacceptable.

- There is a weak clinical voice in decision making, inadequate medical (and wider clinical) engagement, with doctors broadly distanced from management, and with little evidence of engagement with clinical commissioning. This continues to resonate with the MH enquiry that found that 'clinical staff were disengaged, disempowered with a strong sense of not being listened to'.

- We are of the view that the Trust continues to fail to engender an environment in some service areas where clinical staff are able to exercise appropriate judgment, based on their skills, training and experience and deliver high quality care, not least because of the centralist target-driven approach to delivery of care.

- There is an urgent need to change the culture and leadership from one of central control to one in which all staff are positively engaged and involved in determining and delivering safe, high quality care.

- As far as a Foundation Trust application is concerned, whilst the Trust can demonstrate the implementation of structures and processes, Monitor, the Foundation Trust regulator will also look for evidence that the organisation has clinical engagement at all levels of its decision making processes; that the Board accurately understands the quality of care the organisation provides, and that the organisation has a culture where the quality of patient care is the primary concern of all staff.
  Regrettably the conclusions we have reached lead us to conclude that it is not possible for the Trust to evidence these requirements at this time.

1. Background

1.1 The Trust is an aspirant Foundation Trust and its formal application is at a stage where it is dependent on NHS South of England being assured that the organisation is fit to proceed.

1.2 On 22 November 2011, the NHS South of England Patient Safety and Care Standards Committee published two Mental Health Homicide Inquiry reports into the care and treatment of MH and TC. Both investigations, conducted by separate independent investigators, found direct causal links between the care and treatment of the patient and the respective homicides. In other words the homicides could, in the view of each Inquiry panel, have been prevented by proper care and treatment of the patients.

1.3 The Board of NHS South requested a review of the Trust governance, management and other arrangements in order to be assured these systems are robust and patient safety could be assured.

1.4 Terms of reference for the review are attached at Appendix 1

2. Methodology

2.1 The investigation was conducted as follows:

- Face to face interviews on 4th and 5th January 2012 with 40 directors and members of staff of the Trust, and subsequent telephone interviews with a few additional staff, who are listed in Appendix 2. The individuals, from multi professional backgrounds, were chosen in order to provide a representative view of the organisation from Board level through middle management to front line clinical services.
- Interviewing employed a semi structured approach that sought responses to the following themes:
    - organisational structures,
    - processes/procedures,
    - standards of care,
    - people/culture,
    - communication/engagement
    - performance management
    - embedding learning
    - management of change
- Reviewing a comprehensive range of documents and data requested by us and provided by both the Trust and NHS South of England. The list of documents reviewed is at Appendix 3.

3. Context

3.1 One of the largest mental health service providers in the country, the Trust provides adult mental health services to a population of 1.6 million in Swindon, Wiltshire, Bath and North East Somerset, Bristol, South Gloucestershire and North Somerset, and related specialist mental health services in that area and across the South West of England.

3.2 The Trust was formed in 2001 from a number of different Trusts and services, including forensic services, across the whole of the AWP area, all of which had differing standards of performance and management arrangements. We were informed that the initial locality-based services were "separate fiefdoms" and that there was little corporate control.

3.3 On taking up post in April 2006, the Chief Executive (CEO) was faced with an organisation which was failing to meet a number of required standards. She faced a difficult and challenging change agenda in order to address these issues as a matter of priority

3.4 The CEO initiated an extensive organisational re-design which created Trust-wide Strategic Business Units (SBUs) in place of the locality-based and specialist organisational structure. Since then significant progress has been made to put in place comprehensive, co-ordinated, Trust-wide governance structures and processes from January 2007 but nearly six years on from the original restructure the Trust is still beset with ongoing challenges relating to embedding high quality service delivery across all services.

4. Findings

4.1 Structures

4.1.1 In the last 5+ years the Trust has been restructured from a locality based organisation to 4 and more recently 5 Strategic Business Units (SBU) based around the care delivery themes of secure and specialised, adult acute inpatients, drug and alcohol services, liaison and later life, and adult acute community services. Each Business Unit provides services across the geographic area of the Trust. This was a very significant change from the past and, whilst the restructure met with some resistance and the changes might have been better managed and delivered more quickly, overall staff interviewed were positive about the change.

4.1.2 However, the more recent change that split the adult service into acute inpatient and acute community SBUs and which is still being embedded was seen as a top down decision and is, we understand, opposed by a significant number of clinicians. It remains unclear how some aspects of this segmentation of care pathways will work. The acute care pathway is now split across three SBUs (with PICU provision being managed separately), and does not provide an evidence based optimal acute care pathway. This additional complexity will require additional clinical and managerial effort to navigate.

4.1.3 Leadership of each SBU is provided jointly by a Clinical Director who is accountable for the quality, safety and governance agenda and who reports to the Director of Nursing, Compliance, Assurance and Standards and a Service Director who is accountable for finance, performance and operational management and who reports to the Director of Operations. Only one of the five clinical directors is a medical doctor, and it is evident that there is a lack of medical engagement at this level. The Chief Executive told us that doctors do not come forward to express an interest in leadership and therefore do not apply for vacant posts at SBU leadership level. However we were also informed that these roles were demanding, and that they were generally difficult to combine with a continuing active clinical role, something which senior medical staff prefer not to abandon. It was reassuring that there are a number of medical lead posts in the SBUs, and front line staff told us that there was good clinical engagement at service delivery level.

The Swindon locality seemed somewhat deficient in this regard for we were informed that, whilst the senior medical staff were busy and committed to their work, there was a reluctance to get involved with broader Trust management. This appeared a long standing matter, possibly reflecting

a 'lack of enthusiasm' in the clinicians and is highly likely to be related to the chronic inability (i.e. greater than five years) to develop an effective strategy to address poor medical recruitment and retention. More recently a consultant from the 'county' had been brought in to provide medical leadership in Swindon on a part time basis, but he is not from this clinical area and the posting is temporary.

4.1.4 Dual clinical-operational accountability is relatively unusual, as compared with the more usual arrangement whereby one individual (i.e. either the Service Director or the Clinical Director) is managerially ‘in charge’ but some staff have a professional accountability in addition. We found the individual Service Director and Clinical Director post holders were clear about their respective responsibilities and staff in the SBU knew who they were. However in some cases there was a lack of clarity about the different roles, who did what and who was ultimately accountable for the SBU (i.e. ‘the boss’). This has resonance with the MH inquiry report which stated that staff ‘do not know who is in charge’.

4.1.5 At Trust Board level, the Director of Nursing, Compliance, Assurance and Standards is primarily responsible for clinical governance whilst the Executive Medical Director is responsible for strategy and business development. On questioning how the Medical Director/Director of Strategy and Business Development is involved in clinical governance we were told it was through close working with the Director of Nursing and, in addition, the Medical Director chairs a number of clinical governance committees.
There are two Deputies to the Medical Director/Director of Strategy and Business Development, one of whom is a Deputy Medical Director focussing on medical professional issues such as revalidation and the other Deputy Director focusses on performance, strategy and business development.

4.1.6 The MH homicide inquiry commented that in 2007 clinical staff were working in a situation without ‘clear management support and accountabilities’ and we believe this is still the case, at least partially.

4.1.7 Over the last 5 years the Trust has driven a number of redesign projects with varying degrees of successful completion and implementation. Nearly 18 months ago, the Trust embarked on another service redesign project in acute adult services which attempts to provide a single point of entry to services for patients, to deliver seamless care, reduce inpatient bed numbers and deliver improved efficiency. Project implementation has been troubled by many factors, not least the complexities of consulting with multiple PCTs and local authorities. Whilst some staff are unable to articulate precisely what the proposed service model is expected to achieve, others believe it is a good model. The redesign process has however been very protracted, with posts being frozen and some staff having to reapply for their jobs. This is a particular area of concern for some community teams and is affecting morale and possibly the quality of clinical care adversely. This, coupled with the fact that the original Trust restructuring and some previous redesign projects are still not fully embedded, resonates markedly with the concerns expressed in the MH Inquiry about the time taken to implement change and ‘the detrimental effect on operational services’

5.Committee structures

5.1 The Trust Board committee structure is relevant, clear and well embedded. Each committee has clear terms of reference and is chaired by Non-Executive Directors with other non-executives as members.

5.2 For the purpose of this review we focussed on the Mental Health Legislation, Quality and Healthcare Governance and Audit committees. We were assured that the Chairs of the committees understood the work of their committee in considerable detail, that they challenged appropriately

and were not afraid to ask for 'deep digs' into issues if appropriate. We were assured that there is triangulation of evidence between committees and the Board. We were however concerned that committee members 'do not know what they do not know' and there surfaced a particular issue about risk registers to which we refer in more detail in Paragraph 6.1.3.

5.3 The Mental Health Legislation committee is an excellent innovation and is chaired by an extremely knowledgeable lawyer providing significant assurance that the Trust is focussed on adhering to legislation.

6. Processes/procedures/assurance

6.1 Risk management

6.1.1 The Trust has clear risk management policies and processes in place. Essentially risks are identified and recorded at 3 levels. The Business Units identify risks from within their sphere of activity which are recorded on the SBU's risk register. The Executive Directors identify and record risks from within their scope of activity on their directorate risk register. The Director of Operations challenges and scrutinises the risks within the Business Units and the executive team scrutinise each other's risks before agreeing those risks that should appear on the corporate risk register. We are led to believe that there are approximately 300 risks on the SBU and directorate risk registers some of which escalate to the corporate risk register, and we know that there are currently 38 risks on the Director of Operations' risk register and 15 risks on the corporate risk register.

6.1.2 The corporate risk register, as opposed to a list of all the Trusts risks, is scrutinised by both the Audit Committee and the Board.

6.1.3 In our discussion with the Chairman of the Mental Health Legislation committee it became clear that she was not aware of a significant 'safeguarding' risk that was recorded in the Director of Nursing, Compliance, Assurance and Standards risk register but not on the corporate risk register. We would expect a collegiate Board to be party to all information and therefore we recommend that the Audit Committee and the Board scrutinise all the risks recorded in the Trust and make judgements about the number of risks, their grading and whether the mitigations are robust.

6.2 Clinical information systems

6.2.1 The Trust has recently implemented an electronic patient information system – RIO. Almost without exception staff welcomed the move as it supports a huge improvement to patient care. The main benefits are that patient records are available readily to all relevant staff across the organisation, record keeping had improved, and the standard of patient care and safety were better assured.

6.2.2 Criticisms of the system were that it is cumbersome, and staff voiced many concerns at the amount of time spent putting in data in the correct format for non-clinical purposes, particularly the meeting of Trust performance targets. One doctor commented that whilst the system was being implemented there was a moratorium on extracting performance data, and in his view clinical outcomes improved during that period.

6.3 Clinical incident reporting and benchmarking

6.3.1. The Trust incident reporting system is paper-based although there are plans to introduce a new electronic system in March 2012. This is welcomed although it is a concern that we are led to believe that it is not currently technically possible to integrate the new incident reporting system with the RIO clinical record system. This needs to be addressed prior to implementation to ensure

prompt and comprehensive reporting of important clinical-incident information, and that it is documented in the clinical record in a timely manner.

6.3.2 From 1.4.2011 -30.9.2011 (6 months) the Trust recorded 3066 incidents of which 2.5% were classed as RED. It was not clear to the review team how the rate of incident reporting and severity of incidents reported compares to national averages. However we understand the Trust routinely benchmarks their level of incident reporting with other similar Trusts and with the NPSA to evaluate if they are under-reporting serious incidents and this is reported to the Quality and Healthcare Governance Committee.

6.3.3 The Medical Director told us that work to benchmark the numbers of suicides and homicides had been undertaken and the Trust is currently reporting a reducing number of suicides against NHS South West data. The Medical Director expressed concern that there is a lack of available data for benchmarking mental health services more widely i.e. outside of the South West and across other parameters.

6.3.4 Taking into account the population served by the Trust (1.6 million), the expected incidence of suicide in the South West region based on 2008 National Confidential Inquiry data [1] (10.1 per 100,000) and the proportion who will be mental health service users (26%), the expected rate of suicide of Trust service users would be around 45 per year, with 13% (n=5) being inpatients. The latest figures from the 2009 thematic review found that there were 41 incidents of suicide by Trust service users and seven suicides by inpatients (only one on the ward). This data is in line therefore with national averages. It is difficult to conclude too much from these figures as changes may be due to normal fluctuations over time. Nevertheless, the actions resulting from the thematic reviews and lessons learned identified from suicide or suspected suicide incidents need to be part of the Trust's overall suicide prevention strategy.

6.3.5 Reliable benchmarking data for homicides is not available, but raw and partial data from NHS South of England suggests that over the past 6 years the Trust may have had a higher than average number of homicides committed by present or recent patients which the Medical Director acknowledged in his discussions with us. Fortunately the data indicates a possible reduction over the past 4 years.
We were made aware of two alleged homicides committed by Trust service users in 2011 that may or may not be confirmed by court proceedings in due course. Taking into account the population served by the Trust (1.6 million), the expected incidence of homicide in the South West region based on 2008 National Confidential Inquiry data [1] (0.8 per 100,000) and the proportion who will be mental health service users (10%), the expected rate of homicide by Trust service users would be around 1.28 per year. These figures are too small though to allow any significant conclusions to be drawn one way or another. Further analysis would be required to verify the significance of this data.[1]

6.3.6 Suicides and homicides are relatively rare events, and as such should be approached with extreme caution as a performance measure of a mental health service. This is due to a number of factors ranging from random clustering of events (e.g. unconnected leukaemia inceptions around nuclear power stations) through to very accessible services reaching and engaging with a more vulnerable and hence 'risky' population.
Nevertheless, a comprehensive investigation following any individual homicide, using a root cause analysis approach, is a crucial method for modern mental health services to learn important lessons for the future. Also, where there is a clustering of serious untoward events in a specific service which

[1] University of Manchester (2011) The National Confidential Inquiry in to Suicide and Homicide by People with Mental Illness Annual report. July.

has been identified as having difficulties, and where staff are voicing concerns over morale and safety, then clearly there needs to be a system that collates these matters in a supportive fashion, identifies themes and problems in a timely manner and leads to effective remediation.

6.3.7 In AWP Serious Untoward Incidents (SUIs) that merit full investigation and root cause analysis (RCA) are allocated to a member of staff (usually at middle management grade) who has been appropriately trained. Comprehensive RCAs are expected for all SUIs, and we heard that some staff are substantially burdened by this requirement. There are clear timescales for initial and RCA reports which are received by Executive Directors for review and further action. The Non-Executive Directors confirmed that they were notified promptly about SUIs.

6.3.8 The outcomes of investigations are reported to the Critical Incident Overview Group (CIOG) chaired by the Medical Director. However we understand that the Board does not receive any commentary on individual SUIs. We would expect the Medical Director to report on a monthly basis in Part 2 of the Board meetings the numbers of SUIs and the details as known at the time, even if later it does not fulfil the criteria for an SUI. This is important in order that the full Board are cognisant of trends and any serious failures.

6.3.9 The Trust management of SUIs is closely scrutinised by the SHA and the Trust are ranked 57 out of 58 Trusts in England (which is improved from, having been ranked last in early 2011) for the time it takes to report to the National Patient Safety Agency. The Trust has employed temporary staff to clear the backlog, but it remains unclear why there is such a marked delay of 124 days in reporting to the NPSA. Serious untoward incidents are listed on the corporate risk register and Director of Nursing, Compliance, Assurance and Standards risk register as a medium risk despite mitigating action. the Trust needs to consider a more rigorous plan for incident reporting if lessons are to be learned in a timely and productive fashion.

7. Standards of care and carer engagement

7.1 Standard of care

7.1.1 There are a number of methods by which the Trust maintains standards of care at service level. These include management and clinical supervision, policies and procedures to support clinical practice and adherence to NICE guidelines, professional development, and learning from incidents, clinical audits and performance targets.

7.1.2 The Trust has a standard that all clinical staff have at least 10 clinical supervision sessions a year and management supervision monthly. In addition, all staff are expected to have an annual appraisal. We were informed that this extended to medical staff, which could be verified by audit.

7.1.3 Although the Trust performance indicators suggested a shortfall in meeting the target of 85% of staff receiving an appraisal, the supervision and appraisal process was welcomed by all those interviewed. There was some concern that clinical supervision sessions are ‘easily cancelled’ and sometimes not searching enough, but the general consensus was that recent attempts to improve access to clinical supervision had been a qualified success. The personal development plans resulting from the appraisals were viewed as positive and relevant, and we heard several accounts of recent personal and professional developments.

7.1.4 In support of New Ways of Working, extending and enhancing the roles of non-medical staff is evident in the Trust with initiatives in place to develop nurse consultants, senior practitioners and Responsible Clinician posts. Nurse prescriber training was said to be widespread, although this initiative does not appear to have been adopted widely in practice. However, it was not clear how

much of this innovative practice had extended yet to 'hot spots' such as Swindon, where the inability to recruit and retain senior medical staff indicated that this type of initiative was desperately needed. The panel understands that, because of continuing difficulty in recruiting to Consultant Psychiatrist posts in Swindon; it is proposed to replace one of the two vacant psychiatrist posts with a Nurse Consultant.

7.1.5 The performance targets set for clinical services were tolerated at best by those interviewed, and in some cases they preoccupied services at the expense of good quality care (see section 10 below). The indicators developed to measure practice are derived from top-down planning and commissioning processes, with little or no local clinical staff engagement. Therefore, some targets lack clinical validity as indicators of good quality care and are generally viewed as a management target lacking any clinical relevance.

7.1.6 The review team heard that the acute inpatient SBU management team are planning to improve collaboration in developing clinically meaningful targets and we would recommend that this is repeated across the Trust as part of a comprehensive clinical engagement strategy to improve standards of care.

7.1.7 Application of the Care Programme Approach (CPA) is fundamental to safe and effective delivery of mental health services. It was evident from the Trust scorecards that application of the CPA within the Trust was falling short of the required target, at 48% against a target of 80%. Notwithstanding issues around the relevance and validity of the target chosen, it was unclear in general why (at least according to performance data) the CPA was applied so infrequently. We have been told that poor performance against the CPA target is one of the issues being picked up by the Trust's Performance Solutions Group.

7.1.8 Managers of the Crisis Teams, however, reported that key CPA elements such as comprehensive clinical assessment, involvement of carers and development of treatment / care plans were often compromised by the burden of performance indicators, especially the Facilitated Early Discharge (FED) target for weekly contact with all admitted patients and six reviews of each patient within the first two weeks following discharge. By contrast, the Trust has no KPIs which register or measure the Crisis Teams' successful avoidance of hospital admission, a key function.

7.2 Carer engagement

7.2.1 The Trust places great emphasis, from the Chairman down, on service user and carer involvement. The Trust has implemented regular patient and carer surveys, which is admirable in principle. However response rates are variable with response rates as low as 10%; when they were embedded response levels rose to the Trust national survey rate. We heard from staff however that the volume and frequency of surveys is excessive and some carers are refusing to complete more.

7.2.2 The PALS initiatives described seemed very positive. Examples of good practice included the PALS team maintaining links with Trust acute forums and regular visits to service users on wards. Service users are involved in PEAT, equality and diversity initiatives and some service developments, (e.g. website), and service users contribute to staff interview panels and the staff induction.

7.2.3 Given the above it is somewhat paradoxical that there are recurring themes in the complaints report about poor provision of information to and general lack of communication with service users and carers. This was reinforced by findings in the assurance report from October 2011, listening to patient's reports, the quality account and the quarterly Trust scorecard. This is a particular concern given that communication with the families of the two service users was a prominent failing identified in the two homicide reports under consideration.

7.2.4 The Trust has developed a community engagement and involvement policy, which again is admirable, although there needs to be more of a focus on engaging and involving carers and families.

8. People/culture

8.1 Culture

8.1.1 The culture of the organisation is described by the Chief Executive as ‘rising to the challenge under pressure; needs to be performing at a high level all the time, but not there yet’

8.1.2 Staff variously describe the culture of the Trust as:

Reactive rather than proactive
Blaming following SUIs
Supportive in developing managers
“Command and control” response to perceived problems
Good, highly professional clinical staff, many good services
“War weary”, “obsessed with targets”
Staff “whipped” to perform better
Constant change, pressurised, “saps morale”
Poor management of change
Poor external relations
“It is hard to make things simple”
Inert and encouraging bystanders

8.1.3 We observed the culture to be centralist, target driven, bureaucratic and controlling. Some staff seemed reluctant to speak openly, though others were impressively candid. We were particularly surprised to observe that the staff interviewed by us were subsequently asked to complete a form (which we saw) asking for detailed comment on our questions and approach. On day 2 of interviewing we felt that some staff came prepared to answer the questions they thought we would ask.

8.2People

8.2.1 We looked at staff sickness absence as a measure of organisational ‘health’. Staff sickness is currently recorded as 5.3% against a target of 4.8%. We heard that the management of sickness absence is centrally driven and that front line managers believe that on occasions the approach is blunt, punitive and uncaring. We heard that staff are able to access a counselling service provided by an external provider, but this does not appear to be highly regarded.

8.2.2 Recruitment of staff to Swindon generally is problematic and has been for over 5 years. It raises a serious concern about the pace of cultural change and the ability to deliver, quickly, the changes that are necessary to enable the delivery of safe and effective services. We heard that it has been particularly difficult to recruit consultant medical staff to Swindon, and recently only one of 3 vacant posts was filled. The Chief Executive said she was more optimistic now that posts would be filled as the national shortage of qualified doctors is waning.

8.2.3 Retention to the Swindon crisis team in particular remains a serious and urgent concern. We heard that one recent recruit resigned after two days, and another had indicated after 3 weeks that they intended to leave, both reportedly because they were seriously concerned about the safety of the service.

8.2.4 From the reports of clinicians and managers, it was evident that staff morale across the Trust is mixed and that it is very low in some Swindon community services and in some Bristol services.

9. Communication/engagement

9.1 Internal communication is a mixed picture, but with some excellent examples of internal communication methods including Board briefs, *Red Top safety alerts*, Safety Matters bulletins, the use of the Trust's 'our space' and 'Lunch with Laura'; but at the same time there are clear failures to engage and consult staff in a timely manner about a range of issues including organisational changes, performance targets, redesign proposals etc. In a large and geographically spread Trust it is perhaps inevitable that communication lines become strained. We heard a number of times that clinicians and others largely relate to their immediate colleagues, and SBU managers. The central Trust functions are perceived as much more remote.

9.2 The Trust has a well-developed policy on safety walkabouts. The executive directors carry these out on a regular basis and they are well received.

9.3 External communication appears to be less than optimal, some senior Trust staff reporting poor relationships with some commissioners and other stakeholders such as GPs. We were informed that the move to functional SBUs had disrupted many long established and valued local relationships with commissioners, losing significant local knowledge and influence. Although this does not negate the SBU model, it suggests that further work may be needed still to address local stakeholder relationships.

9.4 Commissioner confidence in in AWP appears to be poor, at least as evidenced by NHS Bristol's proposal to tender services more widely and the (unverified) reports we heard of the dissatisfaction of Swindon commissioning GPs with some AWP services.

10. Performance management and target setting

10.1 Performance management

10.1.1 Performance management arrangements are comprehensively embedded and led by the Chief Executive through the executive team. The arrangements include formal monthly performance meetings between the SBUs and Directors, and quarterly meetings between the SBUs with the Chief Executive and executive team. More recently the Chief Executive told us that she had to instate weekly performance and finance recovery board meetings in August 2011 to deal with deteriorating financial performance and risk to delivery of the Trust control total.

10.1.2 Performance management is very process driven, focussed largely on the delivery of targets, which are numerous and many of which are not clinically indicated. Significant and arduous KPIs (some not clinically validated) had been volunteered to or agreed with commissioners by the Trust's Performance Team, without the involvement or agreement of clinical managers. SBU managers describe the Trust's performance framework as "draconian", and that targets are "crucifying" clinical services. The performance management meetings are ineffective in providing support and encouragement, and do not encourage grass roots performance 'ownership'.

10.2 Target setting

10.2.1 Performance contract negotiations are led by the Director of Finance and Commerce supported by the Director of Operations, the Medical Director/Director of Strategy and Business Development and the Trust's Performance Team, who report to the Medical Director, but apparently with little involvement of local service managers and lead clinicians. Therefore

commissioned key performance indicators (KPIs) and CQUIN targets are decided without an effective detailed understanding of their impact on the functioning of the service.

10.2.2 SBU managers told us that they had not been previously involved in the contracting round, and in 2011/12 were not notified of contractual targets until June. Some said that they would be involved this year; but, whilst they are pleased to be included in the preparations for the forthcoming round, they remain concerned about the apparent inability of the Trust's Performance Team to understand or accept their perspective. The Performance Team were described as "arrogant, clinically ignorant and placatory to the executive team".

10.2.3 Other KPIs and target thresholds have been devised by the Trust in addition to those agreed with and monitored by commissioners. Some, especially the Facilitated Early Discharge indicator, are not required by national commissioning imperatives and cannot be achieved without adverse impact on the quality of patient care. The net result for the Acute Community SBU is that service quality (including patient experience, clinical effectiveness and patient safety) is compromised and the Unit's performance dashboard is characterised by a swathe of red RAG ratings, which further damages staff morale.

10.2.4 Many staff told us that some CQUIN targets were not specific, were open to interpretation and therefore were not delivered, with a consequent loss of income, tight weekly Trust performance meetings and a detriment to staff morale.

10.2.5 It was apparent that there had been little or no clinical advice/evidence taken into account in determining targets and key performance indicators, and many appear to have unintended consequences that have a negative impact on quality of care, not least by distracting clinicians from core clinical activity.
Comments from staff included:

> "Self-imposed hurdles –it is like the Grand National"
> "Draconian performance management crucifying services and staff"
> "Big divide between clinical teams and performance team"
> "The tail that is wagging the dog"
> "In handover staff focus on targets not patients"

10.2.6 Of significant concern, in light of the Homicide inquiry reports, is that the focus on delivering the Facilitated Early Discharge (FED) target is reducing the capacity of staff in all of the crisis teams to focus on high risk patient care issues and is causing other unintended consequences that have a negative impact on the quality and safety of care. For example we were told that there is a zero tolerance approach to delivery of the target such that, in order to deliver 6 visits to every patient in the two weeks after discharge from hospital, regardless of whether it is clinically appropriate, some patients who may be recovering and able to return to work or away on holiday are receiving multiple clinically-unnecessary visits, sometimes in one day, in order to meet the target. This is sometimes distressing for patients and diverts staff away from other more important work.

10.2.7 In addition, clinical staff are spending inordinate amounts of time, which would otherwise be spent on therapeutic work, completing data fields in order to ensure this and other targets are not seen as a breach on the data system.

10.2.8 The Specialist Drug and Alcohol Service (SDAS) Business Unit, whose performance is monitored by local Drug and Alcohol Action Teams and the National Treatment Agency, generates a different data set to that required by the RIO system and therefore requires dual input. Nevertheless, SDAS has a mature and effective relationship with its commissioners, and

consequently is better attuned to constructive performance management. This SBU has shown itself capable of the semi-autonomous management and performance which all SBUs are expected to achieve.

11. Embedding learning/change

11.1 There is plenty of evidence that learning points and essential changes of practice are communicated well down through the organisation, particularly through governance meetings within business units and written bulletins. In addition, there is a comprehensive and impressive learning and development plan.

11.2 However, we had reason to believe from evidence that we heard over the two days that the crisis team in Swindon was currently unable to provide a safe service to patients. This was brought to the immediate attention of the Director of Nursing, Compliance, Assurance and Standards, the Director of Operations and the Chief Executive. This evidence had been available over a prolonged period to the Executive Team but apparently had not been registered as a serious concern that required more effective actions, raising questions about the effectiveness of 'bottom up' listening and learning within the Trust.

11.3 We recognise and accept that substantial work has gone in to meeting the recommendations of the homicide report action plans to improve services, in most part by implementing processes. Taking Swindon as a barometer of front line services, however, it is our view that those process improvements are not being disseminated, sustained and integrated into practice across all clinical services, and there are far too many Inquiry findings relating to 2007 that still have resonance now. This is despite the homicide report recommendations being described as ”poor” and out of date by some Trust staff, and the recent ”excellent progress” in addressing the findings of the two reports noted at the November 2011 Trust Board meeting.

12. Conclusions

12.1 There has been significant progress over the past 5 years in putting in place new structures, policies and processes and gaining control of a previously disparate, poorly performing organisation.

12.2 The focus from the Board and executive team is on process and demonstrating target compliance both internally and externally at, we believe, the expense of integrating quality into clinical practice. There is a dominating emphasis on targets, many of which are not clinically indicated and which have a negative impact on quality of care and staff morale. The Trust's performance team, until recently, has developed and agreed performance indicators (including CQUIN targets) with commissioners, but without consultation with clinicians about their clinical validity and deliverability. As a result, service delivery is severely compromised in some clinical areas by the burden of key performance indicators in the Trust scorecards.

12.3 The Chief Executive is actively engaged with and closely monitors the Trust's performance, but is described by some colleagues as having an unduly “command and control” management style, in relation to which the executive directors appear to be placatory. The non-executive directors appear committed and effective, but do not know what they do not know, and accept and inevitably rely to some extent on what the Executive presents to them.

12.4 The Trust's performance management arrangements are very process driven, focussed largely on the delivery of targets which are viewed by some as having little clinical utility. These

arrangements are often seen as punitive and counterproductive, with little evidence of the celebration of success and encouragement of performance 'ownership'.

12.5 There are many statements and conclusions in the MH/TC inquiries that have resonance now. We have used the Swindon services as a barometer of the organisation's health. The MH review identifies the services at the time of CJ's death as being seriously deficient. We have observed the Swindon services 5 years later to still be in a seriously deficient state and this is unacceptable.

12.6 The current service redesign project entails further massive change and inevitable disruption, including a significant reduction of bed numbers and staff. While this may be necessary and in part appropriate, we are far from convinced from the evidence that we have reviewed that the Trust's current culture, capability and capacity will enable a change of this magnitude to be delivered in some services in a timely manner while maintaining safe and effective services. This resonates markedly with the concerns expressed in the MH enquiry about the time taken to implement change and the 'detrimental effect on operational services'

12.7 Some staff have expressed significant concern over the lack of consultation and dialogue about, and the potentially negative impact on patient care of, the on-going SBU structure changes and the present acute adult service redesign project, and have been critical about the length of time it takes to complete change. This is resonant with the MH enquiry that stated that 'staff remain sceptical of and distanced from the change process'

12.8 We are of the view that the Trust continues to fail to engender an environment in some service areas where clinical staff are able to exercise appropriate judgment, based on their skills, training and experience to deliver high quality care, not least because of the Trust's centralist target-driven approach to delivery of care.

12.9 There is a weak clinical voice in decision making, inadequate medical (and wider clinical) engagement, with doctors broadly distanced from management, and with little evidence of engagement with clinical commissioning. This continues to resonate with the MH enquiry that found that 'clinical staff were disengaged, disempowered with a strong sense of not being listened to'.

12.10 The Trust Board are perceived to be distanced from the clinical service and a real understanding of what constitutes quality. There is an urgent need to change the culture from one of central control to one in which all staff are positively engaged and involved in determining and delivering safe, high quality care.

12.11 As far as a Foundation Trust application is concerned, whilst the Trust can demonstrate the implementation of structures and processes, Monitor, the Foundation Trust regulator will also look for evidence that the organisation has clinical engagement at all levels of its decision making processes; that the Board accurately understands the quality of care the organisation provides, and that the organisation has a culture where the quality of patient care is the primary concern of all staff.

Regrettably the conclusions we have reached lead us to conclude that it is not possible for the Trust to evidence these requirements at this time because there is poor clinical engagement in leadership, in change projects and in contract negotiations. The seriousness of the unsafe service we uncovered in Swindon took the Board by surprise and, whilst staff would like and try to make quality of care their primary concern, they are thwarted by the dominating emphasis on achieving targets.

13. Recommendations

13.1 The Board should refocus and change the Trust's culture from a top down centralist bureaucracy to a culture of clinical primacy, inclusivity, engagement and high quality performance ownership.

13.2 The Chairman should review both the executive and non-executive skills on the Trust Board to ensure that there is the requisite leadership skills and ability to lead the change in culture, with an appropriate emphasis on the challenge and scrutiny of clinical quality and safety of care.

13.3 The Board should revisit the Homicide Inquiry reports and consider what other actions need to be taken to remedy the issues identified that are still resonant today and consider how those changes should be effectively implemented. The Board should scrutinise the progress of action on a frequent basis until it is fully embedded.

13.4 The Trust must improve the, consultation, dialogue and speed of organisational change in order to ensure that the burden of implementation does not detract from a focus on the day to day delivery of safe clinical care and staff support.

13.5 The Board should determine reasonable but challenging timescales for major change projects and hold to account those with responsibility for implementation.

13.6 The Board must design, consult on and implement a comprehensive clinical engagement strategy.

13.7 In developing a clinical engagement strategy the Trust must include the need to engage its own clinical staff to work with commissioners to both reduce and simplify the number of KPIs / performance targets, using a clinical evidence base for contracting that focusses on delivering real quality including patient safety. These measures need to be simple, understandable and intuitively relevant to the task in hand so as to bring broad clinical credibility and engagement to the management processes.

13.8 Executive Directors should consult more meaningfully with clinical managers and senior clinicians of all professions about how to engage them more reliably in decisions about service redesign, service delivery and contracting criteria.

13.9 The Performance Management framework should be urgently reviewed and a new approach adopted, which is not so heavily focussed on target achievement but which will enable constructive and supportive dialogue with SBUs over performance and delivery of a full range of issues that impact on quality of care such as clinical audit, research, carer engagement etc In particular, demanding KPIs of little or no clinical validity (especially the Facilitated Early Discharge targets) should be suspended as quickly as possible, in agreement with commissioners when necessary.

13.10 The Trust should make a concerted effort to determine how to improve CPA and related performance across all clinical areas, giving particular emphasis to the service improvements required in the adult community SBU. The Trust needs urgently to review current CPA standards and

operational policies and procedures to determine why there is such a shortfall in performance with a view to implementing remedial action.

13.11 The Audit Committee and the Board should scrutinise all the risks recorded in all the organisation's risk registers and make judgements about the number of risks, their grading and whether the mitigations are robust.

13.12 The Trust needs to have a more rigorous plan for incident reporting if lessons are to be learned in a timely and productive fashion. Ideally the new incident reporting system should be integrated with the RIO clinical record system. Integration issues need to be addressed prior to implementation.

13.13 NHS South of England should consider the possibility of making a range of benchmarked mental health performance data available from across the region to individual organisations to enable more effective local benchmarking of service outcomes.

13.14 The Trust needs to review and rationalise the focus on engaging and involving patients, carers and families.

13.15 The Trust should not proceed with its Foundation Trust application until such time as it has achieved a culture where the quality of patient care is the primary concern of all staff; the Board accurately understands the quality of care that the Trust provides, and there is evidence of effective clinical engagement throughout all the Trust's decision making processes.

Appendix 1

Terms of Reference

The purpose of the review is to provide assurance to the Board of NHS South of England (comprising South Central, South East Coast and South West Strategic Health Authorities) that the corporate and clinical governance arrangements of Avon and Wiltshire Mental Health Partnership NHS Trust are robust. The investigation will:

- review the role of the Board in assuring governance within its organisation, focusing in particular on the governance arrangements at the Trust to protect the safety of people and to assure the quality of care within the Trust and its community services;

- review the effectiveness of the leadership and management of the Trust in ensuring patient safety and quality of care, in particular by reviewing the processes and procedures in place within the Trust and their effective implementation;

- review the arrangements within the Trust and in the NHS locally for effective engagement with staff, key service partners and users and their carers;

- look in particular at the way in which the Board is leading and holding to account the organisation with regard to Serious Incidents (including homicides) from the Board through the service business units to ward/team level;

- look at the number and type of serious incidents occurring in recent years, relating to the services provided by the Trust, benchmarking where possible against national data.

Based on its assessment the independent review team will make recommendations identifying any actions required by the Trust to ensure effective governance and that the Trust proceeds through the FT Pipeline.

The review will be undertaken by an independent multi-disciplinary team on behalf of the Board of NHS South of England and will draw on information arising from meetings, written evidence and interviews.

The review will be led by Susan Sutherland (former CEO of an acute Foundation Trust) working with Dr Michael Hobbs (Consultant Psychiatrist and former Medical Director in a Foundation Trust), Dr Michael Doyle (Nurse Consultant for clinical risk and Programme Director Research and Deputy Director of Clinical Governance

University of Manchester and Dr Steve Colgan (Consultant Psychiatrist and Medical Director in a Foundation Trust).

The review will report by the end of January 2012 to NHS South of England with the intention of the Board receiving the final report at its February 2012 meeting.

Appendix 2

List of interviewees

Chairman
Chief Executive
Non-executive chairman - Audit committee
Non-executive chairman - Mental Health Legislation Committee
Director of Nursing, Compliance, Assurance and Standards
Executive Medical Director and Director of Strategy & Business Development
Clinical Director Liaison and Later Life SBU (Consultant Psychiatrist)
Adult Community SBU Management Team including Clinical Director, acting Service Director, and Swindon Area Medical Lead and Area Manager
Assistant Director of Risk and Compliance
PALS manager
Specialised and Secure SBU clinical team including a modern matron, 2 ward managers and a team manager
Adult Acute Inpatient SBU clinical team including the clinical director, 2 modern matrons, a nurse consultant and a ward manager
Specialised and Secure business unit clinical team including 4 team managers and an acting ward manager
Liaison and Later Life business unit clinical team including the Trust wide head of physiotherapy, a community services manager, a modern matron and a team manager
Adult Acute Community SBU: 4 crisis team leaders
Adult Acute Community business unit clinical team including 4 team managers
Foundation Trust Director

Appendix 3

Documents reviewed

Quality accounts 2010/11
Executive Patient safety visits Terms of Reference
NICE guidance implementation policy 18.01.2011
NHSLA Level 1 assessment report 17.3 2011
Clinical audit and essence or care strategy 2011-14
CQC Review of compliance 08.04.2011
Internal audit report governance (complaints and PALS) 29.6.2011
6 monthly report on incidents and other matters November 2011
Annual incident report and annual incident assurance report 5.7 2011
Trust level balanced scorecard Qtr. 2 2011 and Month 8
SBU scorecards 2011/12 Month 8
Corporate risk register December 2011
NCAS Risk register ? date
Operations risk register including SBU risk registers
Quality Health report – Service users' survey 2011
Quality Health report Mental Health inpatient survey 2011
SHA quality review in support of FT application October 2011
Learning and development Annual report and work plan 2011/12
Integrated patient experience report 26.10.2011
Assurance report on delivery of patient experience strategy October 2011
Mental Health homicide reports action plans and progress to date
Trust Board committee structure diagram
Trust wide governance committee structure diagram
Part 1 and Part 2 Trust Board minutes September, October and November 2011
Trust assurance framework
Risk management policy