

Investigation into

THE NORTH LAKELAND NHS TRUST

Report to The Secretary of State for Health

November 2000

1 On 31 March 2000 the Secretary of State for Health asked the Commission for Health Improvement (CHI) to carry out an investigation into the North Lakeland Healthcare NHS Trust (the Trust), following an inquiry into the abuse of elderly patients by Trust staff.

2 The Trust provides mental health and community services across North Cumbria. Historically, mental health services had been provided from the Garlands Hospital, a Victorian asylum near Carlisle. At the time of the abuse that triggered this investigation, the Trust was in the process of closing Garlands Hospital and re-providing services.

MAIN FINDINGS

MANAGEMENT AND CULTURE

3 A culture developed within the Trust that allowed 'unprofessional, counter-therapeutic and degrading – even cruel – practices' to take place. These practices went unchecked and were even condoned or excused when brought to the attention of the Trust.

4 Some staff CHI interviewed still failed to recognise the abuse which had taken place as unacceptable practice. CHI could not be confident, at the time of their visit, that abuse or malpractice would be reported, or that the Trust would respond effectively to such reports.

5 At the time of CHI's investigation, the Trust's management was in disarray. An urgent priority for the Trust is the establishment of a stable senior team of

skilled managers with the ability to lead the Trust through the difficult period of reconfiguration. Putting the Trust on a sound footing will demand a radical change in the organisation's culture.

6 It is clear that the Trust's failure to ensure the proper treatment of patients resulted from an absence of effective corporate management and clinical governance - a whole systems failure. Executive and non-executive directors alike were responsible for that failure.

7 The Trust failed to ensure that clinical staff were properly involved in decision making. The ways in which the Board operated contributed to the failures in relationships between the Trust and clinical staff, the Trust and the community and particularly between the Trust and people with mental health problems.

8 Many of the staff interviewed for the CHI investigation showed a distrust of management. Many of those interviewed believed that the overriding considerations in the Trust were financial. They believed that measures were taken to reduce staff numbers or downskill in order to meet financial targets. These criticisms were denied by management, but what is clear is that there were failures of management consultation and communication.

9 CHI saw very little evidence of positive relationships or communications between the Trust and its stakeholders or of the involvement of stakeholders in the Trust. Many of the Trust's stakeholders experienced it as closed, inward looking and insular.

WHISTLEBLOWING

10 It seems clear that had the Trust responded positively to the student whistleblowers in 1996 it might have prevented further abuse of the kind reported in 1998. The Trust should publicly acknowledge the courage of the 1996 and 1998 whistleblowers and the important contribution they made to uncovering abuse and the subsequent pressure for change in the Trust.

MEDICAL RESPONSIBILITY

11 CHI encountered widespread concern about the responsibility of doctors for the context in which the abuse occurred. The same consultant was responsible for the patients who were abused in 1996 and 1998. He told CHI that he was made to feel like a visitor on the ward and had not known of the abuse. It is of great concern that despite the earlier investigation, the consultant was unaware of the recurrence of such abuse. CHI is deeply disturbed by the consultant's lack of awareness and passive acceptance of being treated like a visitor on the ward where the abuse occurred. This reflects an inadequate sense of medical accountability in so senior a figure. That the consultant is also the Associate Medical Director and has joint responsibility for clinical governance across the Trust compounds CHI's concern.

12 For such a situation to exist shows that the Trust failed to instil the sense of responsibility a consultant has for the overall care of patients. For this to be the case in 1998 after the events of 1996 is exceptionally poor. CHI found limited evidence of improvement in the

corporate environment that permitted such behaviour.

MONITORING

13 Monitoring of the Trust by external bodies concerned with performance management did not identify and rectify the circumstances which allowed the abuse of patients to develop and continue. Several of these bodies (the Regional Office, the Health Authority, the Mental Health Act Commission and the CHC) told CHI they had anxieties about the Trust's performance over a period of time. Carlisle Mind did report concerns to the Trust and Health Authority. Despite Carlisle Mind's report and the anxieties of the other bodies, no early effective action was taken by any external body to identify the abuse and the Trust's failure to deal with it adequately.

STAFFING

14 In CHI's visits to the sites, it found many clinical staff to be working hard, effectively, and with imagination to provide good service to users. The Trust has been able to recruit a core of psychiatrists, however, the psychiatrists told us they felt under-resourced. Nursing staff told us that nurse staffing levels had been reduced over a period of time. They said that it was not always that absolute numbers were reduced, but F grades were replaced with D grades or even A grades. Some nurses perceived this as a way of saving money. CHI found that the Trust's management systems and procedures were inadequate to enable it to address properly how best to resource clinical priorities. CHI recommends that the Trust undertakes a detailed review of staff required in

clinical, management and administrative posts. This will require developing appropriate processes for managers and clinicians to agree on priorities and how they are to be addressed.

THE WAY FORWARD

15 The Trust Board must have a clear understanding of its functions and priorities. It has to recognise the distinction between executive and non-executive roles. It will need effective representation of members with an interest in mental health services. It will need to make sure that its decisions and policies are informed by a proper understanding of the views of users, carers, staff and other stakeholders. To do this, it will need to become open to – indeed actively seek out – outside views.

16 The NHS Executive Regional Office must, as quickly as possible, work with the Trust to ensure that high calibre managers and clinicians bring excellent clinical and management practice to all aspects of the Trust. This is not an easy task. It is among the most important and should attract the most committed, talented and effective clinical and management staff. It is through their efforts that the appalling abuse that has occurred will be consigned to the past and replaced by a future in which user services are characterised by their rate of improvement and consequential excellence. Those served by the Trust deserve nothing less. The Trust's improvement programme must incorporate appropriate clinical and management leadership development designed to realise the potential that has remained latent within the organisation.

CHRONOLOGY

17 In May 1996 five student nurses voiced concern about physical abuse of patients on Ward 21 at Garlands Hospital. One of their specific allegations was that patients were being tied to commodes. The Trust investigation concluded that there had been 'departures from accepted practice' but these had been with 'good intent'. No disciplinary action was taken.

18 In 1997 Ward 21 was merged with Wards 7 and 29 to create Kielder House, bringing together patients with severe physical disabilities and patients with behavioural problems. It appears that minimal preparation and training were provided to staff to deal with this new patient mix and no risk assessment was carried out.

19 In December 1998 two nurses complained of physical abuse to patients. The investigation by the Trust did not look at issues of abuse any wider than the specific complaints and did not consider the previous incidents. However, their investigation concluded that there was sufficient evidence for disciplinary action. Three staff received disciplinary warnings, one was dismissed and one resigned.

20 In April 1999, at the instigation of the Regional Office, the Trust Chairman established an external review panel to look at the handling of the 1998 investigation and related matters. Their report was published in March 2000.

21 The external review panel found that a range of 'degrading – even cruel –

practices' had been used by some staff and condoned by others. The report listed allegations that had been substantiated, including: a patient being restrained by being tied to a commode, patients being denied ordinary food, patients being fed while sitting on commodes and patients being deliberately deprived of clothing and blankets.

22 The report found that the allegations made by the students in 1996 were similar to those investigated in 1998. It concluded that the 1996 report had '... confirmed and even condoned unacceptable practice...'.

23 Its final conclusion was that 'a flawed investigation into events at Kielder House [ie the investigation of the 1998

allegations] resulted in inadequate action being taken and an unprioritised remedial plan which has failed to address some of the key factors which contributed to the serious mistreatment of patients by a small number of staff.

24 The Trust Chairman has now been dismissed; the Chief Executive is suspended pending a disciplinary hearing; the Director of Personnel has been dismissed; other senior managers have received disciplinary warnings. A new acting Chief Executive from another trust is now in post.

25 The North Cumbria Health Authority is currently consulting on proposals to reconfigure acute, community and mental health services in the whole of North Cumbria.

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1.1 In April 2000, the Secretary of State for Health asked the Commission for Health Improvement (CHI) to carry out an investigation of the North Lakeland Healthcare NHS Trust (the Trust). His decision followed an inquiry at the Trust that concluded that members of staff had abused patients. The terms of reference for the investigation were:

The Commission should investigate the management, provision and quality of health care provided by the North Lakeland Healthcare NHS Trust with particular reference to:

- matters reviewed or investigated by the External Review Panel established in July 1999 by the North Lakeland Healthcare NHS Trust, the North Cumbria Health Authority and the NHS Executive Northern and Yorkshire Region, those matters considered by the internal investigation established by the Trust in December 1998 and the matters set out in the report made to the Trust Director for Mental Health Services in August 1996
- any further matters connected with those Reports and Investigations that the Commission considers ought to be considered further
- arrangements put in place by the Trust for addressing and handling adverse incidents
- the management and provision of health care to those patients with mental health problems, particularly elderly patients, and the psychology and occupational therapy services provided in connection with the care of people with mental health problems

- any steps that may be required to improve the management and quality of health care across all services provided by the Trust, including those to improve participation in planning services by service users, carers and other relevant agencies and the Trust's capacity for improving services

1.2 The CHI investigation team were:

Mr Stuart Fletcher, Chief Executive, Pembrokeshire and Derwen NHS Trust

Mrs Doreen Harrison, Directorate Manager, Birmingham Specialist Community Health NHS Trust

Ms Liz Sayce, Director of Communications and Change, Disability Rights Commission

Dr Jerry Seymour, Consultant Psychiatrist, Community Health Sheffield NHS Trust

THE NORTH LAKELAND TRUST

2.1 The North Lakeland Healthcare NHS Trust was formed in April 1994 by the amalgamation of community and mental health units. It covers a mainly rural area with a large number of sites across North Cumbria. The Trust provides a range of mental health and community health services.

2.2 Mental health services had historically been provided at the Garlands Hospital, outside Carlisle. The hospital was already earmarked for closure, with services being reprovided in a different way, when the new Trust was set up in 1994. The abuse that triggered CHI's investigation took place in the course of the closure programme.

1996: INVESTIGATION OF ALLEGED ABUSE OF PATIENTS IN WARD 21, GARLANDS HOSPITAL

2.3 In May 1996, five student nurses who had been working on Ward 21 at Garlands Hospital, which provided care for older people with mental health problems, reported to their tutor that some staff on the ward were abusing patients. They also wrote to the Trust detailing their concerns. They said that some staff were patronising and bullying, that there was emotional and verbal abuse and 'illegal' practices, such as tying patients to commodes while they had their breakfast. The Trust asked its Patient Services Manager (who later became Risk Manager) and its Training Manager to carry out an investigation. The students were asked to provide further individual statements, which they did. These statements were lost by the Trust and remain so. The students felt that their complaints were not taken

EVENTS LEADING TO CHI'S INVESTIGATION AT LAKELAND HEALTHCARE NHS TRUST

FIGURE 1

May 1996	5 student nurses complain of abuse of patients by staff on Ward 21 at Garlands Hospital.
August 1996	Report of investigation of abuse concludes 'departures from accepted practice, but with good intent'. No disciplinary action taken.
January 1997	Locality Manager responsible for Ward 21 reported she was now confident that patient care was of a 'high standard'.
March 1997	Ward 21 merged with Wards 7 and 29 to form Kielder House.
December 1998	2 bank nurses complain of abuse of patients by staff on Kielder House leading to four staff disciplined. The ward Manager resigned and was reported to the United Kingdom Central Council of Nursing, Midwifery (UKCC) by the Trust.
March 1999	Report on wider implications of the 1998 abuse made 33 recommendations
March 1999	Kielder House patients transferred to the new Pennine Unit. Garlands Hospital renamed Carleton Clinic.
July 1999	External Review Panel set up to look at handling of 1998 investigation and related matters. 1996 investigation comes to light during the review.
August 1999	Chief Executive suspended.
March 2000	External review report found a range of unprofessional and cruel practices on Kielder House, and severely criticised the 1996 investigation. Trust Chairman dismissed and 6 staff suspended or subject to disciplinary action.

seriously and that the managers who carried out the investigation wanted them to drop their complaints.

2.4 The Trust's investigation reported in August 1996. The report concluded that there had been 'issues that are open to misunderstanding', 'departures from accepted practice, but with good intent' and 'issues that require review to ensure that the best approach is being used'. It argued that 'the type of patient in this ward leads to a marked difference between theory and its application' and that 'some of the difficulties encountered between students and staff may have been created by the students' understanding of the relationship between theory and practice'. It made recommendations about how staff should seek authority if they wanted to vary normal practice, for the review of certain practices, for staff training and development in certain areas and for appropriate clinical supervision. It also recommended that 'the outcome of this investigation be fed back quickly to staff and work undertaken with them to rebuild their confidence and morale'. No disciplinary action was taken against any of the staff involved.

2.5 The then Director of Mental Health says that he sent a copy of the report to the Chief Executive and the Locality Manager who took over responsibility for managing Ward 21. The Director of Nursing and Quality says that he did not see the report until August 1999. The Chief Executive says that he did not have sight of the report until late February 1999. No other Board members were told that an investigation had taken place or shown the report.

2.6 In January 1997 the Locality

Manager responsible for Ward 21 sent a note to the Chief Executive and others, saying 'I feel confident that the care given to this difficult group of ladies is of a high standard'.

1997: ESTABLISHMENT OF KIELDER HOUSE INCORPORATING WARD 21

2.7 In 1997, Ward 21 was merged with other wards to form a new ward called Kielder House. This brought together patients with severe physical disabilities and mobile older patients with behavioural problems. The Ward Manager of Ward 21 was given responsibility for the new ward. It appears that only minimal preparation and training was provided for staff to equip them to deal with this new mix of patients and no assessment was carried out of the risks involved in mixing them.

1998/99: INVESTIGATION OF ALLEGED ABUSE OF PATIENTS IN KIELDER HOUSE

2.8 In December 1998 two bank nurses who had worked in Kielder House complained to the then Acting Director of Mental Health about abuse of patients by staff on the ward. They said that they had witnessed physical mistreatment of patients, swearing at patients by staff and uncaring staff attitudes. Six members of staff were suspended from duty. The Director of Nursing and Quality headed an investigation under the disciplinary process. Wider issues of abuse in Kielder House and previous instances of abuse were not investigated. This investigation uncovered other aspects of care that gave cause for concern in the course of its enquiries. Four of the six staff who had been suspended were disciplined. Three staff were given warnings, one Health Care Assistant was dismissed and

the Ward Manager resigned immediately. The Trust referred the Ward Manager's involvement in the abuse to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).

2.9 In March 1999, the Chief Executive asked the Director of Nursing and Quality and the Director of Personnel to prepare a report on the wider implications of the investigation and their report was presented to the Board. They made 33 recommendations that included changes in the Trust's disciplinary procedures. Separately, the Chairman and Chief Executive asked a group of Board directors to look at accidents and incidents that had occurred before December 1998 and the disciplinary processes followed in those cases. The group's recommendations were incorporated into the investigation report.

MARCH 1999: OPENING OF THE PENNINE UNIT

2.10 Also in March 1999, Kielder House patients were transferred to the Pennine Unit, a new 30 bed purpose built unit, on the Garlands hospital site. They were the last patients to be transferred from the old mental hospital. The Garlands site was renamed the Carleton Clinic.

JULY 1999: ESTABLISHMENT OF EXTERNAL REVIEW PANEL

2.11 In April 1999, at the instigation of the Northern & Yorkshire NHS Executive Regional Office, the Trust Chairman (who had been Chairman since 1997) set up an External Review Panel to look at the Trust's handling of the 1998 investigation and related matters. Its report was published in March 2000. The 1996 investigation was not referred to

the Panel and they knew nothing of it until it was mentioned to them after they had begun their work. In August 1999, the Chief Executive was suspended after it was alleged that he had withheld evidence from the External Review Panel.

2.12 The External Review Panel found that a range of 'unprofessional, counter-therapeutic and degrading – even cruel – practices' had been 'used by some staff and, at times, condoned by others'.¹ They found that: staff had brusque and uncaring attitudes to patients, had sworn at, verbally abused and roughly manhandled patients, had fed patients while on the toilet or commode, had restrained a patient by tying him to a commode, had denied patients ordinary food and fed a diet of pureed fruit, bran and yoghurt even when this was not recommended and had deliberately withheld adequate clothing and blankets from patients.

2.13 The External Review Panel noted that several of the allegations made by the students in 1996 were very similar or identical to allegations investigated in 1998. They concluded that the 1996 report had:

*... confirmed and even condoned unacceptable practice and the Panel found it alarming and distressing reading. The Panel were of the view that it was prima facie evidence of a well-established but unacceptable culture in Ward 21.*²

2.14 They said of the investigation of the 1998 allegations that because its terms of reference had allowed for 'little

¹ North Lakeland Healthcare NHS Trust: External Review, March 2000

² North Lakeland Healthcare NHS Trust: External Review, March 2000, page 22

more than an investigation under the disciplinary procedure', it had been unable to tackle the 'appropriateness of the management arrangements' or more serious underlying issues of culture and philosophy.³ It concluded that:

*'A flawed investigation into events at Kielder House resulted in inadequate action being taken and an unprioritised remedial action plan which has failed to address some of the key factors which contributed to the serious mistreatment of patients by a small number of staff.'*⁴

DISCIPLINARY ACTION FOLLOWING THE EXTERNAL REVIEW REPORT

2.15 In March 2000 the Trust Chairman was dismissed and several other senior staff were suspended.

SECRETARY OF STATE'S DECISION THAT CHI SHOULD CONDUCT AN INVESTIGATION

2.16 At the beginning of April 2000, the Secretary of State asked CHI to conduct an investigation.

EVENTS SUBSEQUENT TO THE CHI ENQUIRIES

2.17 In June 2000, the Regional Office facilitated the appointment of a local trust Chief Executive as Acting Chief Executive of the Trust. In July 2000, the Trust announced the disciplinary action that had been taken. The Director of Personnel had been dismissed and the Director of Nursing and Quality, the Locality Manager (Carlisle and District), the Team Leader, the Training Manager and the Risk Manager had all been given warnings. In October 2000, after a disciplinary hearing delayed by sick leave, the Chief Executive was dismissed.

SERVICE RECONFIGURATION PROPOSED FOR 2001

2.18 The North Cumbria Health Authority (the Health Authority) is proposing to change the way health services are provided in the area⁵. It proposes that from April 2001, services will be provided by an acute trust, a mental health and learning disabilities trust and three primary care trusts (PCTs).

³ North Lakeland Healthcare NHS Trust: External Review, March 2000, page 25

⁴ North Lakeland Healthcare NHS Trust: External Review, March 2000, page 43

⁵ Modernising the Management of the NHS in North Cumbria: a consultation document, summary of proposals, North Cumbria Health Authority

3.1 There are issues that were highlighted in the previous investigations at North Lakelands, which remain unresolved, and issues that those investigations did not consider, due to their limited remits. We were greatly assisted in identifying these by Mrs Dianne Jeffrey, Chairman of the External Review Panel. The areas CHI looked at and the questions it asked were:

- **Trust management and culture.** How effective had the Trust Board and management been up to the time of CHI's investigation? Had problems identified in previous investigations been resolved, or, if not, did clear plans exist to resolve them? Were any other steps still needed to put the Trust on a sound footing for the future? Had leadership and management in the Trust been underpinned by an appropriate set of explicit or implicit values? What changes in culture and values were still needed?

- **Staff working on wards where abuse occurred.** Did the Trust now have appropriate standards and expectations for medical staff in respect of their accountability for the care of service users? How had the Trust responded to whistleblowing in the past? Did it now have appropriate policies and arrangements to ensure that any malpractice would be reported and effectively dealt with?

- **Openness and communication.** How effective had the Trust been in establishing arrangements for communication and consultation internally and externally? What steps were still needed to overcome any weaknesses in this area?

- **Relations with the trades unions and professional organisations.** Was there a good working relationship between the Trust and the trades unions and professional organisations representing staff?

- **External monitoring and performance management.** Why had other public bodies, particularly the Health Authority and the Regional Office, not realised that something was going seriously wrong in the Trust?

TRUST MANAGEMENT AND CULTURE

3.2 At the time of CHI's investigation, the Trust's management was in disarray. The Chairman had been dismissed, the Chief Executive and most of the executive directors were suspended or on sick leave and the Regional Office was assisting the Trust by facilitating a number of temporary appointments.

3.3 It is clear that the Trust's failure to ensure the proper treatment of patients resulted from a systematic failure of management. There was an almost complete absence of effective corporate management and clinical governance processes – in effect a whole systems failure. Executive and non-executive directors alike were responsible for that failure.

3.4 A culture developed within the Trust that was described to CHI by stakeholders as closed, inward looking and insular and which allowed 'unprofessional, counter-therapeutic and degrading – even cruel – practices⁶ to take place. These practices went

⁶ North Lakeland Healthcare NHS Trust: External Review, March 2000

unchecked, and were even condoned or excused when brought to the attention of the Trust.

3.5 From the evidence CHI gathered at the time of its visit to the Trust, CHI could not be confident, even at that time, that abuse or malpractice would be reported, or that the Trust would respond effectively to such reports.

3.6 Some of the foundations of the crisis within the Trust may be traced back to its creation in 1994 as the result of a merger between community health services and mental health. Many staff still had a negative view of the amalgamation. CHI was told that the 1994 arrangements were welcomed by the community service staff but were deeply unpopular within the mental health services because the staff felt their service had been 'sidelined and disenfranchised'.

3.7 The 1994 Trust Board staff set up offices in an isolated building, the Coppice, on the main Garlands Hospital site. Clinical staff told CHI that this came to be known as 'Fortress Coppice', indicating the schism that developed between the clinicians and management. The Board and those staff who were known to have influence with it became known as the 'Family' and were seen as a very exclusive and powerful club that could not be accessed by other staff.

3.8 Only one member of the 1994 Board, the Medical Director, a consultant psychiatrist, had direct experience of mental health, the area in which the

abuse of patients later occurred. The Chief Executive had managed the community unit and the Director of Nursing and Quality was not a mental health nurse. The Director of Mental Health was not on the Board.

3.9 The membership of the Board remained substantially the same until 1997, when a new Chairman and four new non-executive directors were appointed. The new Chairman and the Chief Executive failed to develop an effective working relationship, the External Review Panel describing their relationship as 'dysfunctional'⁷.

3.10 The Chairman, feeling that some of the executive directors were underperforming, asked non-executive directors to take on matters that should have been more properly the responsibility of executive directors. For example, one non-executive was given responsibility for a communications review across various hospital sites on which he reported back to the Board and staff forums and meetings. Irrespective of the motives for the new ways of working, staff told CHI that the executive directors at the time found themselves isolated and marginalised.

3.11 Both the 1994 and 1997 Trust Boards were kept in the dark about issues related to the subject of this investigation, which should have been reported to them. A prime example is that the Board was not told about the complaints of the student whistleblowers.

⁷ North Lakeland Healthcare NHS Trust: External Review, March 2000, page 40

3.12 Other significant matters that were not reported to the Board included: an audit by Lakeland College of Nursing and Midwifery of Keswick Hospital raising concerns about nurse leadership, poor record keeping and standards of practice; a clinical audit report of November 1997 on District Nursing Services critical of arrangements for managing District Nursing in the Trust; and an overview of the District Audit Review of District Nursing received in October 1999 highlighting similar criticisms as in the previous reports. These matters were presented to the Board for the first time in January 2000. They were all matters that the Trust Boards should have known about at the time they arose.

3.13 CHI heard many criticisms of the relationship between management and clinical staff. The External Review Panel found that 'clinically important decisions are made which consultants are not consulted upon and consultants feel that they are excluded from having a direct role in management'⁸. They reported that what they had been told was a general view among clinicians that the Trust's management structure did not 'lend itself to receiving clinical advice'¹⁹.

3.14 Staff interviewed by CHI expressed similar sentiments and showed a distrust of the motivations and powers of management. There was, for example, a belief that the then Director of Personnel (since dismissed) was able to dictate staffing levels and the skill mix of staff without reference to clinical advice. Staff from a number of disciplines, and working at various levels,

said that there was no adequate system for identifying and prioritising clinical staff training and education needs.

3.15 Many of those interviewed believed that the overriding considerations in Trust planning and operational management were financial. The Trust management denied that this was so. CHI found that the Trust's management systems and procedures were inadequate to enable it to address properly how best to resource clinical priorities. In short, the poor systems meant that CHI was unable to conclude whether or not the Trust was under-resourced.

3.16 An urgent priority for the Trust is the establishment of a stable team of skilled senior clinical and non-clinical managers with the ability to lead the Trust and to regain the confidence of those, internally and externally, who have been betrayed by it. The Trust must recognise the crucial relationship between high quality leadership and the consequential impact upon the quality of patient care. To make this happen, the appointment processes for all the Trust's management jobs (including clinicians with managerial responsibility) must be of the highest standard. CHI is aware that at least one recent appointment of a consultant to a position with senior management responsibility in the Trust caused considerable consternation among a number of stakeholders. The Trust will want to examine the processes it has used in making senior appointments and may wish to review whether all such appointments have been appropriate.

⁸ *North Lakeland Healthcare NHS Trust: External Review, March 2000, page 38*

⁹ *North Lakeland Healthcare NHS Trust: External Review, March 2000, page 38*

STAFF WORKING ON THE WARDS WHERE ABUSE OCCURRED

MEDICAL STAFF

3.17 CHI encountered widespread concern inside and outside the Trust about the responsibility of doctors for the context in which the abuse in Ward 21 and Kielder House occurred. CHI was asked many times, 'Where does medical accountability lie in this situation?'

3.18 The consultant responsible for patients in Ward 21 in 1996 was interviewed for the investigation of that year. The same consultant was also responsible for patients subjected to the abuse that occurred in 1998. He was not interviewed as part of the 1998/9 investigation because he was on sick leave from early November 1998, a month before the complaints were made, until early May 1999. He told CHI that he had been made to feel, '...like a visitor' on the ward and had not known of the abuse. It is of great concern that, despite the earlier investigation, the consultant was unaware of the recurrence of such abuse. CHI is deeply disturbed about the consultant's lack of awareness and the passive acceptance of being treated, '...like a visitor' in the ward in which the abuse occurred. This is an inadequate understanding of medical accountability in so senior a figure. That the consultant is also the Associate Medical Director and has joint responsibility for clinical governance across the Trust compounds CHI's concern.

3.19 For such a situation to exist shows that the Trust failed to instil, in at least

this practitioner, the sense of responsibility a consultant has for the overall care of patients under his or her charge. For this to be the case in 1998, after the events of 1996, was exceptionally poor. CHI saw limited evidence of improvement in the corporate environment that permitted such behaviour.

THE WHISTLEBLOWERS

3.20 CHI talked with two of the nurses who, as students, had spoken out on the abuse they had witnessed in 1996 and with the two nurses who had complained of abuse of patients in 1998. In both cases, the whistleblowers brought fresh eyes into an otherwise inward focused ward culture.

3.21 Despite the introduction of a Trust whistleblowing policy in 1999, it became obvious from CHI's interviews with the whistleblowers that they have had a very difficult time in the Trust. At times they have been intimidated and pilloried by other staff within the Trust and in the local area. They told CHI that it was only since the publication of the External Review report that they have been accepted a little better within the Trust. Other staff also told CHI that the hostile attitude to the whistleblowers had not entirely gone; for example, some staff did not want to work a shift with them.

3.22 Inadequate response to whistleblowing has featured in many of the recent inquiries into failures of NHS services. In this case it seems clear that had the Trust responded positively to the student whistleblowers in 1996 and taken appropriate steps to implement and reinforce good practice, it might

have prevented further abuse of the kind reported in 1998.

3.23 The Trust has only recently publicly acknowledged the importance and bravery of what the whistleblowers did. It would help in convincing staff and others that the Trust will in future respond positively to whistleblowing if it now reinforces that acknowledgement.

STAFF WHO WERE ACCUSED OF ABUSE OR WITNESSED ABUSE

3.24 CHI interviewed two of the three staff who received warnings as a result of the 1998 complaints (the third had been dismissed for an unrelated offence). CHI also interviewed another who had been accused of abuse in 1998, although not disciplined, and who still worked for the trust. All three had worked on Ward 21 at the time of the 1996 complaints of abuse. They told CHI that they had received little training since 1998 and none, except on control and restraint, relating to the care of difficult patients.

3.25 Some staff told CHI that in contrast to what happened to the whistleblowers, at least some of those accused of abusing patients received a lot of support from colleagues. CHI was also told that staff who supported those accused of abuse had withheld evidence from the External Review. The External Review Panel itself reported that the Director of Nursing and Quality had told them that 'a major problem with the investigation (of the allegations made in 1998) had been the unhelpfulness of

staff'.¹⁰ The essence of clinical governance is that it is as unacceptable to fail to report poor practice as it is to be guilty of poor practice.

3.26 Some staff told CHI that in 1996 and 1998 some of the bad practices had become the norm and that junior staff were not aware that they were doing anything wrong. One member of staff who received a warning about abuse of patients in 1998, told CHI that he/she thought that the Sister's word was law, and that an unqualified member of staff had no right to question what the Sister said or did.

3.27 Some nursing staff told CHI that they felt deeply hurt and let down by their colleagues' bad practice. Others CHI interviewed still failed to recognise the abuse that had taken place as unacceptable practice. Some of those who CHI interviewed were responsible for monitoring the performance of staff who denied that the abuse had happened. They felt it was very unfair for them to have to monitor the performance of those who denied the abuse and to be held accountable for their practice.

3.28 Comments to CHI suggest that managers and staff may still not fully understand or be fully committed to their obligations under the whistleblowing policy. **Staff should receive training about the Trust's whistleblowing policy, so that they are fully aware of their responsibilities and of the ways of reporting poor and abusive practice.** Equally, it should be made clear to managers, through training and guidance, that they are

¹⁰ North Lakeland Healthcare NHS Trust: External Review, March 2000, page 37

expected to take allegations seriously and that disciplining or victimisation of any one making allegations of malpractice in good faith would constitute a disciplinary offence and be treated accordingly. To remove any lingering fears of victimisation, it would be helpful to identify members of staff to whom any concerns could be addressed in confidence and who would have the authority to initiate appropriate enquiries. It is also important that managers should 'walk the wards' and make staff comfortable about approaching them with any concerns.

OPENNESS AND COMMUNICATION

3.29 The Trust has a poor record of sharing information or listening to and taking account of the views of others. The Trust Board became isolated from its own staff, its service users, the public at large and the media. Planning and management in the Trust had been carried out with little or no involvement of clinical staff, service users, carers, their advocates or others with a legitimate interest.

3.30 In the course of its enquiries CHI heard and saw very little evidence of positive relationships or communication between the Trust and stakeholders, or of the involvement of stakeholders in the Trust. One stakeholder described the Trust as, 'physically, emotionally and educationally' isolated. Generally, external stakeholders and many staff found the Trust to be inward looking, unresponsive and even secretive.

3.31 Trust staff told CHI that the Trust's failure or refusal to be communicative

led to the media having to adopt an investigative approach and rely on out of date or leaked information. For example, when some staff were suspended as a result of the complaints of abuse in 1998, there was negative and out of date coverage in the local paper which, staff thought, could have been avoided if the Trust had openly and promptly communicated accurate information. There was a more open approach to the publication of the External Review report in March 2000 and as a result there were no staff leaks and there was balanced coverage including a full apology from the Trust for what had occurred, and information on action to improve care.

3.32 Internal communications have also been inadequate. Staff told CHI it was a 'standing joke' that if they wanted to know what was going on they had to read the local newspaper. Trust newsflashes (brief reports to all staff of an event that is likely to be taken up by the media) have recently been introduced. However, they are not a substitute for properly organised processes of two-way communication and consultation with staff. There are many approaches to this, including structured staff meetings and forums. Those to whom CHI spoke at the Trust thought staff forums were not valued by staff in general and were seen by some as a way of pushing through changes in terms and conditions or as a 'talking shop'. However, staff forums can be a means to ensure that staff become fully informed of developments and plans and that their views and experience are properly taken into account. Forums can also be a channel for staff to raise questions and express views and

concerns, provided they feel they can do so without fear of adverse consequences.

3.33 Some of the Trust's published material is out of date and uses language that is not readily accessible to patients and carers. For example, the complaints leaflet had an incorrect address for the Health Service Ombudsman (corrected following CHI's visit). At the time of CHI's visit, the Trust lacked publicity material that would help make its services and policies clear and accessible to users and carers.

3.34 CHI takes the view that high quality patient care and relationships are most likely to flourish in a culture which;

- is open and communicative about its own policies, priorities and decisions
- is responsive to the views and criticisms of users and other key stakeholders and promotes their involvement and participation in planning and development
- is founded on respect for all, including those with mental health problems and other disabilities, as equals entitled to fair, decent treatment

3.35 The culture at the Trust appears to have fallen well short of these standards. However, with many changes in management in progress and reconfiguration in prospect, there is a clear opportunity to make a fresh start. **This should include the explicit adoption of a clear set of agreed**

values, with the full involvement of service users, carers and staff, which would then underpin all the Trust's work. The Trust will also need to adopt, among other things, more open, proactive strategies for consultation and communication with users, carers, staff and the wider public.

3.36 At the time of the CHI investigation, there were signs that attitudes and practices were beginning to change, but far greater change is needed. To be effective in the future, the Trust needs to adopt a radically different approach based on genuine openness and responsiveness. One element of this should be a Patients' Council with a formal link into Trust decision-making bodies. A methodology such as the Sainsbury Centre's User Focused Monitoring, which trains users locally to monitor services and propose improvements which can then be measured might also be useful.¹¹ The Trust should also consider how to extend and support advocacy services.

3.37 CHI notes the attempts by an Acting Director of Mental Health (in post until June 2000) and others to initiate contact and consultation with stakeholders. This is a new approach for the Trust, and one that may have helped to avoid some of the difficulties had it been implemented earlier.

TRADE UNIONS AND STAFF ORGANISATIONS

3.38 Relations between staff organisations and management have sometimes been strained. However, at

¹¹ *In Our Experience – User-focused monitoring of mental health services (London: Sainsbury Centre for Mental Health)*

the time of CHI's investigation, the staff organisations demonstrated to CHI unequivocal support for moving forward and for improvements in patient care. Representatives of the trades unions and professional organisations told CHI that they had been concerned for a number of years about the closed culture of management which had almost entirely excluded staff from involvement in decisions. The trades unions and professional organisations felt frustrated and excluded from discussions to improve practice and working conditions. They were particularly concerned at the lack of progress in forming an effective health and safety committee and training staff in risk assessment. They said however, that the situation had begun to change in the weeks before the CHI investigation team's visit. The potential now exists for a positive partnership between the Trust and the staff organisations to help take the Trust forward. The Trust must seize the initiative and create the climate in which this will occur.

EXTERNAL MONITORING AND PERFORMANCE MANAGEMENT

3.39 None of the external organisations that had any responsibility for scrutinising the Trust identified the circumstances that allowed the abuse of patients to develop and continue. This is a failure of the whole health system. Several of these bodies (the North Cumbria Health Authority, the Northern & Yorkshire NHS Executive Regional Office and the Mental Health Act Commission), told CHI that they had anxieties about the Trust's performance over a period of time.

3.40 Both the Health Authority and the

Regional Office said they had concerns about the Trust's handling, recording and reporting of adverse incidents. The Health Authority said there had been 'robust' discussions with the Trust about incident reporting, but that the then purchaser/provider boundary had become a barrier to establishing exactly what was happening in the Trust. The Health Authority said that the performance management that was required of them nationally seemed to be more about numbers and money than quality. They added that locally they did pursue quality issues and they gave CHI examples concerning one of the community hospitals. The Regional Office told CHI that the Trust had been considered not to have a strong management team, but it had delivered what was required. The numbers of adverse incidents reported by the Trust were not considered by the Regional Office to be so high or so low as to raise concerns. The Regional Office were, however, concerned as to whether there were signals which they could have identified from the Trust which would have highlighted the need for earlier intervention. They questioned how it was possible to ensure in future that they and the Health Authority picked up on incidents in the 'quiet corners'.

3.41 The Mental Health Act Commission (MHAC) told CHI that its Chief Executive had raised concerns that the management of Kielder House was unsatisfactory and that patients were receiving inadequate attention, in a letter to the Trust's Chief Executive in December 1998, which was copied to the Chief Executive of the Health Authority and to the Regional Office. The MHAC advised CHI that its remit is

confined to detained patients. When the MHAC comment on the care of non-detained patients there is a danger of exceeding their statutory remit. For some time before their December 1998 visit, which had led to the concerns being raised, there had been no detained patients in Keilder House, and in those circumstances Mental Health Act Commissioners would not have visited routinely.

3.42 Carlisle Mind was the one organisation that did raise concerns about abuse of patients. They showed CHI correspondence beginning in January 1998 about their concerns that patients with dementia were being inappropriately restrained. The Director of Carlisle Mind wrote initially to a member of the Independent Reference Group that was advising the Government on mental health services. The letter was passed to the Health Authority for a response and on 17 April 1998 the Chief Executive responded to Carlisle Mind saying that neither the Health Authority nor the Trust 'have any knowledge of any complaints regarding residents being inappropriately restrained ...We would be very surprised if this allegation is correct'. The letter asked Carlisle Mind to let the Health Authority have any further information they had on this matter. Carlisle Mind responded that they considered their sources on this matter to be reliable and, as they felt that the allegations could have substance, had made both the Health Authority and the Trust Board aware of them so that they could be investigated. Neither the Health Authority nor the Trust took any further action.

3.43 The Community Healthy Council's evidence was that by 1998 its organisational relationship was stronger with the local acute trust than with the North Lakeland Healthcare NHS Trust. The CHC had raised concerns about all continuing care wards during the mid 1990s and in 1996 were informed by the Trust that some problems had occurred on Ward 21 which were being dealt with through disciplinary procedures, although the CHC were not given any details of the allegations.

3.44 Despite Carlisle Mind's report and the anxieties of the other bodies, no early effective action was taken by any external body to identify the abuse to which patients were subjected and the Trust's failure to deal with it adequately. This is a matter of great concern.

3.45 CHI acknowledges that it is difficult to identify deeply hidden abuse through occasional visits, and that all monitoring systems have their limits. The national guidance on the role of Health Authorities and Regional Offices (see appendix D) indicates that they had a limited role in monitoring and performance management of the day-to-day running of services provided by Trusts. However, even if the Health Authority did not have effective mechanisms for uncovering the abuse itself it should at least have fully followed up the concerns raised by Carlisle Mind.

3.46 There are helpful guides to identifying abuse that the Trust and the Regional Office will want to draw upon. In particular, Angela Pedder's analysis of NHS incidents which have led to

inquiries, cites a number of factors which always seem to be present.¹²

3.47 Both the Health Authority and the Regional Office are concerned that such abuse should never happen again in the North Lakeland NHS Trust or the trusts that succeed it. The strengthening of the role of Regional Offices in respect of NHS organisations which are seen to be struggling or failing means that Regional Offices will address carefully how they will identify and respond to such organisations in the future.

3.48 When the abuse happened, the main responsibility for discovering and preventing it lay with the Trust Board. The failure to follow up fully the concerns raised by Carlisle Mind is a stark example of the Board's failure to exercise this responsibility. It was and is

the Board's responsibility to set and maintain appropriate standards of care and treatment of patients in all areas. Trust Boards operate with a high degree of autonomy. With this autonomy goes a clear responsibility to ensure that corporate and clinical governance processes have as their objective the highest standards of patient care and the complete absence of abuse or mistreatment of patients. Part of CHI's role is to examine the arrangements that trusts have to ensure the highest standards of patient care and the avoidance of any form of abuse. CHI will review all the new trusts to be set up through the proposed reconfiguration in Cumbria one year after their creation.

¹² *The Anatomy of a Disaster – paper given at the South West Regional Clinical Governance 2000 conference, available from the Royal Devon and Exeter NHS Trust*

In the terms of reference for the investigation the Secretary of State asked CHI to look at the Trust's arrangements for handling adverse incidents. This chapter looks at this issue.

ADVERSE INCIDENTS

4.1 When things go wrong and adverse incidents happen, it is important that they are recorded and the learning points used as a tool to improve patient care. The Trust's policy on dealing with adverse incidents, dated October 1998, was prepared after the North Cumbria Health Authority had written to all North Cumbria NHS trusts about the reporting of untoward incidents.

4.2 The Trust's policy covers the definition of adverse incidents and sets out what staff should do to record and report such incidents. Serious adverse incidents are investigated within the Trust and reported as appropriate. The Trust told CHI that they now meet the 48-hour deadline for summary reporting of serious incidents to the Health Authority and Regional Office. CHI was told that for the last 18 months a quarterly report was made to the Board giving a summary of adverse incidents and drawing attention to any significant trends. The Trust follows the same procedures as other trusts for reviewing the death of anyone who has been using its services.

4.3 The Trust told CHI that in recent months it had worked hard to improve its management of incidents, accidents and complaints and to link them to each other. The Trust uses a 'blue form' system

for staff to report all accidents, adverse incidents and 'near misses'. When an adverse incident occurs a form is completed and sent to the Risk Manager. The Trust thinks that its new system has improved reporting, although it acknowledges that some areas are better at reporting than others and that further work with those areas is required.

4.4 CHI examined accident and adverse incident data supplied by the Trust. If current trends continue there will be 1720 reported incidents during 2000 compared to 1278 for 1999. The Trust's analysis highlighted two areas of concern; the continuing number of needlestick injuries to staff and the high number of patient falls or patients found on the floor. It was not possible to establish whether the higher number of reported adverse incidents resulted from improved reporting, declining standards, or some combination of the two.

4.5 The most crucial aspect of adverse incident reporting is that everyone should see it as part of a programme of improvement in patient care rather than a fault-finding process. Reporting needs to be consistent and reliable and there needs to be a determination to analyse how and why they occur and to act to stop them happening again. Such analyses are likely to be most effective if carried out with the participation of staff, users and carers in an open partnership rather than as a 'top-down' management effort. The Trust has the beginnings of such an approach and with new management CHI hopes it will pursue it vigorously and imaginatively.

4.6 A prime example of adverse

incidents is the number of patients fall. Their number suggests an urgent need to look at why they happen and what could be done to reduce their occurrence. The participation of users and carers as well as staff would help to develop the most reliable analysis of risks.

COMPLAINTS

4.7 Like adverse incident reporting, responding to complaints is best seen as part of an organisational learning process aimed at improving patient care. Responses should acknowledge the complainant's distress and fully explain the reasons for what happened. In cases where something went wrong, they should also assure complainants that action would be taken to avoid it happening to anyone else. Any general trends in the subject matter of complaints and their outcome should be analysed and followed up, so that steps are taken, such as modifications to practices or procedures, staff training or accommodation or equipment as appropriate, to prevent the recurrence of complaints.

4.8 To be effective, a complaints process must be properly understood by users and staff and have their confidence. The Trust's policy is being rewritten and this provides an opportunity to re-launch the procedure and convey to users, carers and staff that complaints are valued as opportunities for improvement and will be taken seriously. The way in which complaints are handled and the style and content of the responses to complainants should then reinforce that message.

4.9 The Trust receives about 60 complaints each year. It aims to acknowledge receipt within 48 hours and provide a full response in four weeks. In 1999/2000, there were 54 complaints, of which 36 related to mental health services. At the time of the CHI visit, the Health Service Ombudsman was investigating one complaint about the appropriateness of discharge arrangements for a patient.

4.10 The Trust told CHI that a report on new and outstanding complaints is made to the Board on a monthly basis. The report gives a summary of each complaint, together with the findings and conclusions.

4.11 CHI looked at complaints relating to Kielder House between 1997 and 1999 and considered a random sample of recent complaints. Some responses seemed to be defensive and rather dismissive in tone and failed to acknowledge the complainant's distress. Other responses were rather formal, but the letters covered the main areas of concern. Where complainants considered the initial responses inadequate, the Trust supplied further appropriate information.

4.12 CHI also talked to stakeholders about their experience of making a complaint. Some stakeholders told CHI they would be either afraid to complain, or could not see the point since they felt that management action did not often follow from discussion with users. One family told CHI they did not feel their distress was acknowledged, nor were they reassured that action would be taken to reduce the risk of painful events happening again.

The Secretary of State asked CHI to look at the management and provision of health care to those patients with mental health problems, particularly elderly patients, and the psychology and occupational therapy services provided in connection with the care of people with mental health problems. This chapter considers these issues.

VISION AND LEADERSHIP

5.1 In the course of CHI's investigation, stakeholders and staff told CHI repeatedly that there was still no vision or overall strategy for mental health services, despite the External Review saying that 'an urgent action plan for the Old Age Psychiatry Service ... should be the development of a vision for the service as a whole, shared with other stakeholders'.¹³

5.2 The vision should make clear the standards of service to be aimed for, the values which underlie them and, therefore, the kinds of actions which are unacceptable. It should be arrived at with the participation of all those concerned – management, staff, service users and their carers and other stakeholders – to command general support and commitment. The Trust's Action Plan refers to a North Cumbria strategic development group for older people with mental health problems, which is aiming to develop such a vision.

5.3 CHI noted that the Trust was making some efforts to visit services in other areas to seek examples of good practice. This followed 'red traffic lighting' of the Health Authority in April 2000, which meant that the Regional

Office thought the Health Authority had made insufficient progress in implementing the National Service Framework for mental health. There is clear value, particularly for an organisation that has tended to be inward-looking, to study practice and experience elsewhere and CHI would urge the Trust to develop this approach.

THE GENERAL ATMOSPHERE IN HOSPITALS AND WARDS

5.4 CHI visited various clinical areas in both mental health and community services. The overall impression was of many enthusiastic staff working hard and doing their best to provide a good service to patients. Patients with whom CHI spoke, expressed general satisfaction with the service they received. However, in several areas staff were unhappy with the level of support they received from management and frustrated by a lack of multidisciplinary working. For example, some told CHI that they virtually never saw their managers on the wards and that the first time some staff had met their manager was at a disciplinary meeting.

5.5 In the Pennine Unit (which replaced Keilder House, scene of the 1998 abuse), staff said that the recent allocation of two F Grade Sisters had helped enormously to ensure good practice, but that previously they lacked sufficient guidance and supervision. A project nurse had been assisting unit staff to develop standards and to undertake clinical audit. This was encouraging, but staff need leadership within the Trust to take the service forward.

¹³ North Lakeland Healthcare NHS Trust: External Review, March 2000, pages 32 and 34

5.6 The Hadrian Unit has a high number of beds (33) and this, combined with the layout of the Unit, made it difficult for staff to observe all patients effectively. From the evidence obtained from interviews and visits, CHI also concluded that the admission procedures for the Hadrian Unit should be reviewed so that medical staff and nurses work more closely together in deciding the sort of case mix which can be nursed appropriately. Risk assessment also needs to be established on the ward.

STAFFING

5.7 CHI heard from psychiatrists and psychologists that there were too few of them and from nurses that they had concerns about a reduction in nursing staff and whether work was being done by appropriate grades of nurse. The best approach to tackling these issues is a review of the services provided by the whole Trust and the number and seniority of staff, clinical, management and administrative, needed to support those services properly. The review should be carried out with the active participation of users, carers and advocates, whose views of the services required and the standards to be aimed at should have particular influence.

MEDICAL SERVICES

5.8 Following a low point in consultant staffing in 1994, the Trust has been able to recruit and retain a core of consultant psychiatrists. In addition to telling CHI that they felt there were not enough psychiatrists, they also said they had expressed their

frustration at the poor support they had received from the Trust Personnel Department, for example, in the practicalities of advertising posts and employing locums. CHI heard criticism that some psychiatrists did not work in a multidisciplinary fashion. The psychiatrists argued that this related to a lack of opportunity to do so, rather than a lack of willingness.

5.9 It is crucial that there should be sufficient psychiatrists to meet the needs of patients, provide for appropriate supervision, and carry out audit, risk management and necessary training. The staff CHI interviewed felt that there were insufficient staff at both consultant and non-consultant grades, however, CHI found that the management systems and procedures were inadequate to reach conclusions on staffing levels. The Trust must undertake a full review of the staff levels and mix required to meet its clinical priorities.

NURSING SERVICES

5.10 Nursing staff told CHI that the Trust had reduced nurse staffing levels within the mental health service over a period of time. They said that it was not always that absolute numbers were reduced, but F grades were replaced with D grades or even A grades. Some nurses perceived that as a way of saving money. The ward managers worked 9.00am to 5.00pm, and this meant that in the absence of F grades, the E grades were expected to take charge of the whole hospital site out of hours. CHI felt that even with the H grade nurse providing an on-call service, that is an unacceptable burden for this grade of

nurse and exposes these staff and the service users to an unacceptable level of risk.

5.11 In the early years of the Trust, the H grade nurses (team leaders) had been reporting to the locality managers, who were not mental health trained: this meant that they had no access to professional advice within the Trust. The management structure was changed in 1997 when a site manager was appointed for the Garlands site. Whilst this, in principle, offered extra support to the nursing staff, the post holder experienced differences of view with the medical staff and was removed. The Director of Mental Health was on prolonged sick leave at the time and the H grades were left without professional support, reporting directly to the Chief Executive. This left them in a very vulnerable professional and management position, with excess responsibilities for the grade. Following the publication of the External Review report, an Acting Director of Mental Health (who had a background in mental health nursing) was seconded to the Trust and the team leaders reported to that post holder. Staff told CHI that they found this person and her successor, who is not a nurse, but who has a wide experience of mental health, to be supportive.

5.12 CHI was told that there was a lack of a training strategy or formal educational opportunities for nurses, particularly qualified staff. CHI was also told, however, that there was also little uptake of opportunities that did exist. Staff of the local nursing college told CHI that the uptake of courses from

staff at the Carleton (formerly Garlands) site was poor. The main training effort seemed to be in the area of National Vocational Qualification (NVQ) (level 2) for unqualified staff. While it is commendable that this training is being undertaken, it is also important that professional staff are given opportunities to undertake further education and keep themselves up to date with contemporary practice. In the community hospitals, there was evidence of more staff being encouraged to undertake higher education, and a few staff were doing advanced nursing practice courses.

5.13 On the wards, policy folders contain policies on clinical practice and management issues. CHI found many of these to be out of date. There was an absence of clear policies, procedures and supervision on the wards and consequently an inability to identify and rectify problems at an early stage. The localities in the past had operated as fairly autonomous entities and the Trust had not been proactive in standardising policies. In the absence of a corporate drive in this area, local procedures had sprung up. This situation means that the Trust does not have the basis for setting and monitoring uniformly high standards across its services and locations, which will be essential to meet clinical governance requirements.

5.14 CHI noted that Trust nurses in mental health were less well qualified and more junior than in other areas. A District Audit report¹⁴ noted a ratio of 84:16, qualified to unqualified staff, among district nurses. In comparison, Trust figures show a ratio of 60:40,

¹⁴ District Nursing, North Lakeland Healthcare NHS Trust, 1998/9

qualified to unqualified staff, in mental health. There was a contrast in the grading structure of qualified staff within mental health and community services. In mental health, staff were mostly D and E grades; in community nursing they were G, H and I grades. Inability or unwillingness to tackle these issues reinforces the impression that the needs of people with mental health problems were not priorities.

PSYCHOLOGY SERVICES

5.15 The psychologists told CHI that they thought the Trust had limited psychology services, especially in the area of adult mental health and elderly mental health. They described this as 'trying to survive on a minimal level of provision'. CHI was told that a part time psychologist had been employed on Kielder House for a time and made an impact on the way patients' treatment programmes were managed. Staff on the Pennine Unit (formerly Kielder House) made a strong plea to CHI for input from the psychology department. They felt that psychology services were an essential component of a comprehensive, contemporary mental health service. It was clear that in other parts of the Trust, for example Child and Adolescent services, psychologists were working effectively and creatively in a multidisciplinary fashion.

5.16 The psychologists told CHI that they thought the Trust had limited psychology services, especially in the area of adult mental health and elderly mental health. They felt that psychology services were an essential component of a comprehensive, contemporary mental

health service. As stated earlier, CHI found that the management systems and procedures were inadequate to reach conclusions on staffing levels and resourcing. The Trust must undertake a full review of the staff levels and mix required to meet its clinical priorities.

5.17 The psychologists felt that they were insufficiently involved with commissioners and managers in planning the level of service provision. CHI was also told that when the service had attempted to expand, the Health Authority had dismissed this as 'empire building' and said that existing staff should take on new roles. The psychologists were not prepared to do that as they felt they were already spreading themselves too thinly. There were also concerns that if the Trust reconfiguration went ahead as planned, current difficulties would be compounded because of ongoing recruitment problems in West Cumbria.

5.18 The provision for elderly patients at the time of CHI's investigation was one whole time equivalent assistant psychologist who, because of supervision issues, could not currently perform neuropsychological testing. Between 1986 and 1996 there had been 0.4 whole time equivalent consultant clinical psychologist and one whole time equivalent assistant psychologist. The psychology department head took the view that the establishment of an appropriate psychological team in the area would facilitate the development of a more psychosocial approach to the care of elderly patients and that 'in the light of recent events ... evidence based practice from other areas should be

incorporated! Following the team's visit, the head of department informed CHI in a letter that she has taken advice from the Psychology Special Interest Group in the Elderly (PSIGE) who have recommended that the department acquaint themselves with the other models of care and take account of other sources of expertise.

5.19 It is important that there should be a review to test the clinicians' views that they are under-resourced and to establish if there are better ways that existing resources might be used. The review should look at re-establishing a clinical psychology complement to Elderly Services as well as other areas of need such as Forensic Services, and consider the need for further development across the Trust.

OCCUPATIONAL THERAPY (OT) SERVICES

5.20 Users and staff told CHI that inpatient units provided no stimulation for patients. Users in priority day care told CHI that they 'sit there doing nothing all day'. This indicates a pressing need to increase opportunities for activity so that users are supported to achieve what they want to achieve in, for example, education, employment, housing, parenting and social life. Both for elderly and younger service users, there is a need for a thorough on-going assessment of rehabilitation needs, linked to users' preferences. This should involve both Occupational Therapy input and access to a range of opportunities for ordinary and supported activities, which may be provided by, for example, local users, user-led projects and voluntary agencies.

5.21 In common with other areas within the Trust, OT services were, until recently, delivered through a flat management structure which meant that there was no leadership to advise on professional, staffing and other issues. Shortly before CHI's investigation the Trust decided to appoint two head OTs, one to be responsible for mental health and the other for community services. CHI met the OT responsible for mental health services and a number of other mental health OT staff. They acknowledged that there were problems nationally with the resourcing of OT services, but thought there were particular concerns about the Trust's OT provision. The general concerns of the mental health OT staff were about the lack of OT resources as they saw it; that there had been no professional management structure; that there was limited multidisciplinary working; that there were no dedicated treatment areas (valuable time was spent setting up and taking down equipment); and that in terms of support staff they were 'bottom of the pile'.

5.22 The Trust's OT services were described by the mental health OTs as 'very traditional' and the head OT for mental health was concerned to improve services to clinical areas. He was compiling a service plan for the Acting Director of Mental Health. His view was that because OT services had been fragmented with no overall head, it had been easy to 'pick off' individual posts and that had resulted in reduced budgets and diminished patient care. At present, the Trust has 7.68 whole time equivalent's for community OT and 11.82 for mental health. Staff of the Pennine Unit told members of the team that they felt there was a need for a greater input

of OT for elderly patients with mental health problems.

5.23 Mental health OT staff were also concerned about the impact of the proposed reconfiguration on the service they provided. They wished to have the opportunity to stay together and develop as a professional group, but understood that it was likely that they would be split between the Primary Care Trusts and the mental health and learning disabilities trust. They were opposed to that because they thought they would become isolated professionally, which was not conducive to their personal development or that of the service.

5.24 In the course of discussions about the provision of OT services, staff referred to the abuse of patients on Ward 21 and Kielder Ward and the allegation that the OT department had put together a restraint device which was used to keep patients on commodes. The mental health OTs said that no such device had been produced or purchased by the OT staff. That is contrary to the External Review report (page 33, paragraph 9.3.11) which says that the Director of Nursing and Quality told the External Review Panel that he found during the 1998 investigation that a wooden board and harness had been made in the OT department for use on Kielder Ward. In spite of determined inquiries, the CHI investigation team was unable to clarify this matter further.

GENERAL COMMENTS AND CONCLUSIONS

5.25 In CHI's visits to the sites, CHI found many clinical staff to be working

hard, effectively and with imagination to provide good service to users. CHI found that the community hospitals were highly regarded in their local communities and linked well with community psychiatric nurses and primary care. They have potential for further development with the introduction of Primary Care Trusts.

5.26 However, several general concerns arise:

- there was no clear vision or overall strategy for mental health services for elderly people which would guide planning, decision-making and standards of service, although the development of a long-term vision was part of the Action Plan arising from the External Review report
- there appeared to be a general lack of clarity about appropriate arrangements for management and supervision, particularly of ward staff across the Trust and for developing and maintaining high standards
- staffing levels and skill mixes in various areas need review to ensure that appropriate and consistent criteria are applied and that the Trust can show that its complement and staffing structure are based on clear, verifiable criteria
- there was a lack of up-to-date, consistent policy on clinical practice and management of the kind which would be necessary for effective clinical governance
- in a number of areas there was a lack of interdisciplinary working between different disciplines and between Trust staff and other agencies which, if

developed, would enable the Trust to achieve better value from its staff and

- staff training and education, particularly in mental health, was not based on a needs analysis and organisational development programme which would ensure that training was planned and provided in the best interests of users and staff.

Finally, the Secretary of State asked CHI to address any steps that may be required to improve the management and quality of health care across all services provided by the Trust, including those to improve participation in planning services by service users, carers and other relevant agencies and the Trust's capacity for improving services. This chapter addresses these issues.

CLINICAL GOVERNANCE

6.1 The NHS Executive 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.'¹⁵

6.2 Since June 1999, the Trust has taken a number of steps to develop its clinical governance arrangements. These have been delayed because of the events that triggered this investigation. The Trust has made progress recently, but it must ensure that clinical governance is effective across the Trust as soon as possible.

QUALITY OF HEALTH SERVICES

6.3 Both staff and service users brought issues about improvements in the quality of health care to us. Overall, the service was seen as somewhat 'old fashioned'. Many of the suggestions

made for improvement did not require increased funding. For example, user groups, carers and staff repeatedly told CHI that ward staff spent too much time in the office rather than with patients. As one user put it, 'we talk to the domestics more than the nursing staff – they have more time'. Another user reported via his Community Psychiatric Nurse that he 'got less care when he went into hospital' than in the community. Some users told CHI they did not always see a keyworker, or even in some cases know who the keyworker was. They did not feel they were seen holistically in hospital; that is in relation to matters such as their job, housing and children, rather than just their healthcare. Staff attitudes could on occasion be a problem. For instance, staff sometimes regarded concern expressed by a patient as a symptom of his or her illness, rather than a valid view or criticism about Trust services.

6.4 Staff and users told CHI that inpatient units were lacking in stimulation. Users advised that they 'sit there doing nothing all day'. CHI was also told repeatedly that senior managers had not listened sufficiently to clinicians' views on what was needed. Positive proposals, for example, for home treatment, had not been taken forward. Members of staff also argued that some inpatient provision was simply unnecessary and that people with long-term mental health problems could be supported to develop and sustain lives outside. The concentration upon inpatient provision was inadequate for their needs. One member of staff commented, 'they have integrated

¹⁵ *Clinical governance: Quality in the new NHS, NHS Executive*

teams¹⁶ in Northumberland 30 miles away – but we can't get it off the ground here'. A nationally renowned rehabilitation team had been disbanded some years earlier, though it was not clear why that had happened. This is an example of where better use could be made of existing resources rather than extra resources being required.

6.5 Many of the matters brought to the attention of the team indicated inadequate planning by the Trust. For example, the recent temporary closure of Orton Lea, a respite care facility for children with disabilities, apparently occurred because the European Working Time Directive placed constraints on staff rostering options. Parents pointed out to CHI that the Directive had been known of 18 months previously, yet the decision was taken so suddenly that some children turned up for respite only to be turned away. When CHI visited, parents were unable to plan for more than one week ahead, as respite could no longer be agreed in advance. The Director of Cumbria County Council Social Services commented to an investigation team member that he could not understand how a decision on temporary closure was not communicated to him or the Health Authority, or even to some Trust staff, until after it had happened. For him this raised questions about the internal management, supervision, communication and culture of the Trust. The local Mencap group has written to CHI to make clear the distress and concern caused by the way the service was closed without prior notice to parents and users, which they feel is

'symptomatic of a Health Care Trust unable to manage front line services adequately'. CHI has recently learnt that the service reopened in September on a full-time basis with the appointment of three additional nursing staff.

6.6 The words 'ad hoc' and 'piecemeal' came up repeatedly in discussions on Trust services with stakeholders and staff. For example, stakeholders told CHI of some facilities without clear eligibility criteria (e.g. Orton Lea). Staff told CHI that consultants operated inconsistent or arbitrary criteria for admission to the same ward, sometimes applying different criteria to the same patient at different times. Some policies were lacking (for example, the Trust had no policies on user involvement, on confidentiality or on ethnic minority issues) and others were not consistently implemented. One of the locality managers is bringing together policies and procedures for the community hospitals, which is to be welcomed. In general, whilst some practice is good, there are concerns about consistency of practice.

USER AND CARER INVOLVEMENT

6.7 User and carer involvement with the Trust remains marginal. One user commented, 'we may be listened to about colour schemes, but not about the siting of the hospital'. CHI considers that marginalisation of user involvement holds back progress in improving services. Advocacy workers and volunteers are ideally placed to hear any concerns users may have and raise them

¹⁶ *Integrated nursing teams bring together nurses employed by, for example, GP practices and community trusts, so that they work more effectively together*

with staff, but they have faced difficulties on some wards. Trust staff told CHI that some staff see advocates as 'a threat' or 'a nuisance'. This is unacceptable. The picture that emerges is one of some limited good practice, coupled with considerable resistance across the Trust to provide effective channels for users to influence decision making.

6.8 From the good practice within the Trust, CHI cites some examples of effective user involvement. The Trust responded positively to requests from users to produce some information leaflets on medication (although information materials could be further improved). When users objected some years back to being asked to queue in their nightclothes for medication, men and women together, the practice was changed promptly. However, there is, as one stakeholder put it, 'no flow from user involvement into Trust policies'. User involvement remains marginal, according to staff and users. For example, some stakeholders told CHI that they would have preferred single sex toilet provision on the Hadrian Unit, but that was not addressed by the Trust. The Trust informed CHI that they believe there are ample single sex toilets on the Unit. They acknowledge, however, that bath and shower facilities are mixed sex, adding that, 'it would be fair to say that the Unit was not well designed in a number of respects, including separation of men's and women's washing facilities'. CHI would refer the Trust to national guidance¹⁷ and to the help available from NHS Estates staff in the Regional

Office.

6.9 Shortly before CHI's visit, service users and carers had been given places on the North Cumbria mental health programme board, which is a positive step, but as yet they do not seem confident that they can influence real change. There is a need to ensure they can contribute strongly. The Trust's Head of Psychology has established a user group, which is valued, but it has no clear route of influence into Trust policies or practices. She also plans to fund users to investigate models of user involvement in different parts of the country.

6.10 The team found that the marginalisation of user involvement is holding back service improvement. For example, the Trust rejected the suggestion that users could participate in the clinical audit group. This is unfortunate, as user involvement in audit can be extremely useful in ensuring that user priority outcomes are audited (see for example, the audit methodology used in South West London and St George's Mental Health NHS Trust rehabilitation services, which builds user defined outcomes into the audit process each year).¹⁸

6.11 Another example of marginalisation was the vivid description by one user of how inaccessible the Carleton Clinic site could be. She needed psychotherapy services but could not access them because she could not afford the childcare necessitated by the

¹⁷ See circulars HSC 1998/143 and EL(97)43 and EL(97)3

¹⁸ Perkins RE, Hignet D and Benton A (1996) *At Your Service? Involving Users in a Quality Audit in a Psychiatric Rehabilitation Setting*. In Thompson K and Strathdee G (eds) *Effectively Managing Mental Health Service Development*. London: Sainsbury Centre for Mental Health.

four hour round trip. Access to services within Carlisle would be vastly preferable. The hospital was 'stuck out of town – not trying to put roots out into the community'. Some of the stakeholders told CHI that if users had been effectively consulted, they would have pressed for a Carlisle base.

6.12 There are sometimes seemingly minor issues that can signal to patients the value that those responsible for NHS services place on them. One such example in the Trust is that of refreshment facilities in the Carleton Clinic. As one user put it, the contrast between the extremely cramped users' coffee bar (like a 'disused railway carriage') and the 'palatial' staff dining room 'shouts out to us what they think of us'. A staff member thought that it 'reinforces the negative views users have of themselves'. Users should be involved in discussions about different options for resolving this issue. These might include open use of the dining area, or the establishment of a separate, good-sized users' area. The impression which some users currently have, that they are not permitted in the staff area because staff 'do not want to mix with them', needs to be countered. Fully shared dining rooms in hospitals are now widespread good practice. As a particular example, CHI would refer the Trust to Raeside, a high security forensic unit in Birmingham, which has a joint dining room for staff and patients, with no sectioned off area.

GENERAL COMMENTS AND CONCLUSIONS

6.13 A key element to improve the quality of patient care across all services is strong and effective clinical governance. CHI recognises that the Trust has recently begun to make progress in respect of its statutory responsibilities for clinical governance, but action has been severely delayed because of matters arising from the 1998 abuse on Kielder House. The Trust must now make all possible efforts to implement effective clinical governance mechanisms.

6.14 The picture that emerges of user and carer involvement in mental health services is one of some good practice coupled with considerable resistance across the Trust to providing channels for users to influence decision-making either directly or through advocacy services. Steps taken to improve the management and quality of health services must be based on a proper understanding of the views of users and carers about the services that are needed and how they should be provided. The resistance to the involvement of users, carers and other stakeholders therefore needs to be confronted and positive steps taken to strengthen user and carer involvement.

7.1 The way forward to a properly functioning Trust will not be easy. It will be vital to have management that is strong and effective and also open to the needs and concerns of service users, carers and staff. Without such management, the Trust will not get through the difficult period before and immediately after reconfiguration. It will also be vital for the Health Authority and Regional Office to review what has happened and learn lessons from it.

7.2 The profoundly disturbing whole system failure, which allowed the abuse of elderly people to happen, must never be allowed to happen again. It is time for the Trust to move forward. The circumstances that permitted such unacceptable behaviour must be addressed with urgency and skill. This requires a strong commitment to new organisational values, energy and determination to improve the care of service users. These qualities must become evident throughout the Trust.

7.3 It is opportune that reconfiguration is being planned at this time. This offers an opportunity to create arrangements for corporate and clinical governance that will ensure that all the new Trusts provide the highest quality of care. The issues discussed in this report are, therefore, extremely relevant to the reconfiguration proposals. They will need to be carefully considered by the Reconfiguration Board, especially those on effective interdisciplinary ways of working and interagency co-ordination.

7.4 Our findings will also continue to be of relevance to the new trusts. The mental health and learning disabilities

trust, and the other local trusts which are to be created in April 2001, must fully assimilate the action plan arising from CHI's investigation to ensure that there is absolutely no possibility of a return to the dysfunctional behaviour that has been so damaging for service users. This does not, in any way, diminish the requirement of the present Trust and others concerned with its achievement of successful performance to drive forward an action programme to overcome the toxic factors that allowed patients to be abused.

The priorities for the Trust and CHI's specific recommendations are:

MANAGEMENT AND CULTURE

The Trust Board must have a clear understanding of its functions and priorities. It has to recognise the distinction between executive and non-executive roles. It will need effective representation of members with an interest in mental health services. It will need to make sure that its decisions and policies are informed by a proper understanding of the views of users, carers, staff and other stakeholders. To do this, it will need to become open to – indeed actively seek out – outside views.

The NHS Executive Regional Office must, as quickly as possible, work with the Trust to ensure that high calibre managers and clinicians bring excellent clinical and management practice to all aspects of the Trust. This is not an easy task. It is among the most important and should attract the most committed, talented and effective clinical and management staff. It is through their efforts that the appalling abuse that has occurred will be consigned to the past

and replaced by a future in which user services are characterised by their rate of improvement and consequential excellence. Those served by the Trust deserve nothing less. The Trust's improvement programme must incorporate appropriate clinical and management leadership development designed to realise the potential that has remained latent within the organisation.

RECOMMENDATION 1

The Trust Board should undertake a development programme with the objectives of ensuring that:

- a) the Board includes strong representation of members with knowledge of and interest in mental health services and has access to high level, credible advice
- b) all members have a clear understanding of and commitment to effective corporate management and clinical governance in all services provided by the Trust
- c) all Board decisions and policies are informed by a proper understanding of the views of users, carers, staff and other stakeholders arrived at through a thorough-going process of consultation and genuine openness to ideas, comment and suggestions from outside
- d) to demonstrate openness, Board business conducted in private session is reduced to the minimum

RECOMMENDATION 2

The Trust should seek to establish a new, stronger Trust management team and should:

- a) appoint managers with the outstanding skills needed to enable the Trust to put behind it the problems of

recent years and implement the new approaches to management urgently needed to carry the Trust forward as an effective body

- b) ensure that all management decision making takes proper account of the views of clinical staff
- c) recognising the inevitable differences of perspective between management and clinical staff on financial and other constraints, make it a clear requirement that managers must be able to show in all planning and decision making that a proper balance has been achieved between conflicting organisational priorities
- d) ensure that effective systems are put in place for staff, user, carer and other stakeholder participation in planning and decision making
- e) establish appropriate systems for assessing and implementing the training and education needs of staff in the best interests of individuals and the Trust, ensuring that staff are fully aware of training opportunities and the reasons why any applications they make for training are not successful
- f) revise the staff appraisal system to ensure that all staff are aware of what is expected of them, how their performance will be measured and what training and development will be available to support them

RECOMMENDATION 3

The Trust should review its corporate values and initiate a process of establishing an explicit statement of values that will underpin all its policies and decisions and its relations with Trust users, carers, staff and other

stakeholders.

The Trust should in particular emphasise respect for all people, including elderly people suffering from dementia or other physical or mental disabilities, as equals entitled to fair, dignified treatment as a foundation on which all the Trust's policies and practices are built.

RECOMMENDATION 4

The Trust should develop an effective quality improvement strategy and practice that extends throughout the Trust. This will enable the Trust Board to bring effective stewardship to the improvement of patient and client services and must be developed as a matter of urgency.

TRUST STAFF

There must be effective engagement of staff in promoting the new values of the Trust. There is a core of hard working and positive staff in the Trust who provide good patient care and are anxious to take the Trust forward. Staff must be supported through good practice development (through effective clinical governance, monitoring and supervision) by recognising and building on positive practice.

RECOMMENDATION 5

As a matter of urgency, the Trust should carry out a fundamental whole service staff skill mix review to ensure an appropriately skilled workforce to care for the Trust's patients/users. The review of the skill mix and establishment should include clinical, management and administrative posts (which should include administrative support for the wards). The review should be strongly influenced by the service needs as perceived by service users and their

carers, advocates, relatives and friends. This work will help serve those to be cared for by the successor trusts.

The Trust should develop and implement a multidisciplinary, multiagency approach to the delivery of services, ensuring effective co-ordination of different disciplines within the Trust and between Trust staff and social services .

RECOMMENDATION 6

The Trust should extend and reinforce its whistleblowing policy by:

- a) publicly acknowledging the courage of the 1996 and 1998 whistleblowers and the important contribution they made to the uncovering of abuse and the subsequent pressure for change in the Trust
- b) making it clear that former and future whistleblowers will be protected from any form of harassment or victimisation, and that any such harassment or victimisation, including a refusal to work with a whistleblower, is a disciplinary offence and will be treated as such
- c) emphasising the importance of staff reporting poor practice, as part of the development of clinical governance, and the possible consequences of failing to do so. Making it clear to staff that all concerns will be treated seriously and sensitively and provide training and guidance accordingly
- d) creating arrangements for staff who so wish to raise issues in confidence with named managers with the authority to initiate appropriate enquiries

RECOMMENDATION 7

The Trust should examine the processes it has used in making senior

appointments and may wish to review whether all such appointments have been appropriate.

RECOMMENDATION 8

To clarify responsibility for quality, the Trust should:

- a) review the way in which the responsibility for standards and quality has been allocated, particularly in relation to the responsibility of medical staff for the care of patients on wards, and create clear lines of management and clinical accountability for all categories and grades of staff. All staff must be engaged in effective appraisal
- b) ensure that accepted good clinical governance practice is adopted by all disciplines through concerted and sustained programmes of training and education

COMMUNICATIONS

There must be effective far reaching internal and external communications programmes. These programmes must be developed speedily to replace the Trust's previous inadequate arrangements.

RECOMMENDATION 9

The Trust should develop a proactive communications strategy, ensuring that all key policies and plans are published and available to users, carers, other stakeholders, staff and the media. Accurate, timely information should be published internally and externally on all developments of public interest, whether negative or positive from the Trust's point of view.

RELATIONS WITH THE TRADE UNIONS AND PROFESSIONAL ORGANISATIONS

RECOMMENDATION 10

The Trust should build a positive partnership with the trades unions and professional organisations in working to improve services to patients and the conditions of staff, especially in respect of health and safety, training and risk assessment.

EXTERNAL MONITORING AND PERFORMANCE MANAGEMENT

RECOMMENDATION 11

The Regional Office and the Health Authority should review their procedures to establish if there were any measures which they could or should have taken which would have helped to uncover and stop the abuse of patients, taking account of existing guidance on the danger signals, and develop more appropriate monitoring systems to prevent any repetition of what happened in this or another Trust. The Regional Office will need to consider this especially, in view of its strengthened role as set out in the NHS Plan in respect of NHS organisations that are seen to be struggling or failing.

ADVERSE INCIDENTS

RECOMMENDATION 12

The Trust should explore the reasons for the high numbers of patient falls which have occurred and continue to occur on the Pennine Unit and take appropriate action urgently to reduce the risks of falls and implement a regular audit of falls.

COMPLAINTS

RECOMMENDATION 13

The Trust should:

- a) re-launch the complaints procedure with a view to ensuring that staff, users, carers and others know that complaints are valued as opportunities to improve services and will be treated seriously
- b) establish a system for monitoring and analysing in depth the matters which are complained about to identify patterns and trends in the issues raised, changes in practice which have been made as a result of complaints, and any more general action which may be required
- c) ensure that complainants are informed not only of the outcome of a complaint, but also where action is taken as a result of their complaint. Staff should also be informed of the outcome of complaints and helped to develop their practice to prevent similar future complaints

NURSING

RECOMMENDATION 14

To strengthen the role of nursing, the Trust should:

- a) review all nursing standards to ensure that they are current, based on evidence and good practice, implement any changes necessary, and create a regular system of monitoring and reporting
- b) ensure through the review of staffing levels and skills mix recommended elsewhere, that nursing staff have adequate supervision and support to enable them to function to an appropriate standard
- c) through the Director of Nursing,

ensure that negotiations with the Education Consortium identify appropriate resources to ensure that continuing education needs are met, especially in terms of clinical supervision, risk assessment, clinical governance and Post Registration Education and Practice (PreP) requirements

CLINICAL GOVERNANCE

RECOMMENDATION 15

The Trust should now move forward to establishing comprehensive and effective clinical governance procedures as a matter of urgency. Experience should be drawn from established good practice including reference to the NHS Executive's National Clinical Governance Support Team.

USER AND CARER INVOLVEMENT

RECOMMENDATION 16

The Trust should ensure the effective involvement of users, carers and others in the planning and provision of health care services by:

- a) establishing, in consultation with service users and through study of the best practice elsewhere, the most effective systems for building users' priorities into the Trust's planning and decision making
- b) establishing a Patients' Council with a formal link into Trust decision-making bodies
- c) ensuring that in all planning and decision making at Board and management levels, account is taken explicitly of the views and suggestions of patients, their relatives and other carers, and other stakeholders about the

services needed and the way in which they should be provided

d) immediately signalling its intent in respect of its relations with users and carers by sharing facilities such as the dining area, or establishing a separate, well-equipped users' area of a good size

ALL SERVICES

RECOMMENDATION 17

The Trust should carry out a review, to be completed by December 2000, of all Trust policies on clinical practice and management issues, to ensure that they reflect good practice and are in accordance with legal and/or statutory requirements.

RECONFIGURATION

RECOMMENDATION 18

The Reconfiguration Board should take

careful note of the issues discussed in this report, so as to ensure that the final arrangements for the leadership and management of health services will deliver the highest standards of service to users.

HADRIAN UNIT

RECOMMENDATION 19

The admission procedures for the Hadrian unit should be reviewed so that medical staff and nurses work more closely together in deciding the sort of case mix which can be nursed appropriately. Risk assessment also needs to be established on the ward.

The Trust fully accepts the recommendations in the Commission for Health Improvement report and a detailed action plan with clearly defined timescales and responsibilities for implementation and monitoring will follow. The Trust is committed to:

1) Undertaking a comprehensive development programme for all its Board members by 31 December 2000 at the latest. For example, clinical governance training with the British Association of Medical Managers (BAMM) took place on 26 October 2000.

2) Ensuring that a strong, experienced and credible Senior Management Team at Board level and effective management arrangements are maintained i.e. there are now three new Executive Directors in post with Mental Health Experience.

3) Reviewing and redefining its corporate values in conjunction with users, carers, staff and others as part of the preparation for the proposed new Trusts in April 2001.

4) Emphasising respect for all people in the Trust's care particularly elderly people with dementia and the severely disabled by establishing a Patient's Council with representation on the Trust Board.

5) Publicly acknowledging the contribution and courage of the 'whistle blowers' in 1996 and 1998 in uncovering the abuse of patients.

6) Reviewing the allocation and responsibilities for standards and quality across the Trust particularly in respect of senior medical staff using support of the Northern Centre for Mental Health.

7) Continuing to develop a proactive communication strategy and develop positive working relationships with Trade Unions and professional bodies.

8) Working with users and carers' representatives to examine the reasons for a high number falls on the Penine Unit and take any action if required.

9) Relaunch the revised Complaints Policy by 31 December 2000 emphasising that the receipt of complaints is valued as an opportunity to learn about and improve services.

10) Undertaking a comprehensive review of staff and skill mix throughout all services managed by the Trust in conjunction with users, carers and key partner agencies. This has already been initiated in Mental Health nursing, medical staffing, occupational therapy and psychology services.

11) Continuing to review all nursing standards to ensure they comply with best practise.

12) Continuing to develop comprehensive and effective clinical governance arrangements as a matter of urgency based on best practise and externally validate by January 2001.

13) Undertaking a review by 31 December 2000 of all Trust policies on clinical practise and management issues in order to ensure that they comply with best practise.

Nigel Woodcock

Acting Chief Executive

TEAM MEMBERSHIP AND METHODS USED IN THE INVESTIGATION

The investigation was carried out for CHI by a multidisciplinary team, comprising a NHS Trust chief executive, a senior nurse, a lay person with relevant experience and interests and a consultant psychiatrist. The CHI team members were drawn from areas outside Cumbria. They were:

- Mr Stuart Fletcher, Chief Executive, Pembrokeshire and Derwen NHS Trust, Wales
- Mrs Doreen Harrison, Directorate Manager, Birmingham Specialist Community Health NHS Trust, Moseley Hall Hospital, Birmingham
- Ms Liz Sayce, Director of Communications and Change, Disability Rights Commission, Manchester
- Dr Jerry Seymour, Consultant Psychiatrist, Community Health Sheffield NHS Trust, Nether Edge Hospital, Sheffield

They were given specialist support and advice by Dr Linda Patterson, CHI Medical Director and Mrs Liz Fradd, CHI Director of Nursing, who oversaw the investigation and the reporting of it. The investigation process and report writing was managed by Ms Chris Ranger, a CHI Investigation Manager, and further supported by Mrs Margaret Tozer, a second CHI Investigation Manager.

PLANNING AND CONDUCT OF THE ENQUIRIES

In preparing for the investigation, CHI reviewed and analysed the previous reports referred to in the Secretary of State's terms of reference and sought a variety of other documentation from the Trust. (A list of documents reviewed by the investigation is in appendix e.) CHI wrote to 428 local organisations and individuals with an interest in the services provided by the Trust (collectively known as stakeholders) inviting them to submit information about the Trust to us. The investigation also received wide publicity in the local media, through which people were encouraged to contact us.

In May 2000, CHI devoted three days to meetings with stakeholders. CHI received information relevant to the investigation from 65 organisations and individuals. CHI interviewed 12 stakeholders and spoke to 20 others on the telephone. At the request of Carlisle Mind, CHI attended a meeting with its members. Another 32 stakeholders submitted information in writing. An analysis of the concerns raised by stakeholders is given in appendix C.

CHI then spent one week of intensive enquiry at the end of May gathering evidence orally and in documentary form at the Trust. The names and positions of all Trust staff interviewed, along with those from other local NHS organisations, are given in appendix B. Disciplinary action associated with the previous investigations was pending against several senior and other staff whom CHI needed to interview, and this presented some difficulties since disciplinary matters were outside CHI's

remit and were naturally sensitive. CHI also visited three community hospitals and five wards within the Carleton clinic, which provides mental health services. In the course of those visits, CHI interviewed some staff and service users. Details of the locations visited are also given in appendix B.

The investigation was intensive but brief, and there were inevitably many matters raised, which CHI was not able to follow up in detail. The objective was to formulate a sufficiently clear, reliable understanding of the current state of the Trust and the context in which any difficulties had arisen, to enable CHI to make appropriate recommendations for the way forward.

LIST OF THOSE WHO GAVE EVIDENCE

The Trust

The whistleblowers:

- two nurses who were students on Ward 21 (later Kielder Ward) in 1996

- two bank nurses who worked on Kielder Ward in 1998

A nurse who was the subject of allegations about the treatment of patients on Ward 21 in 1996 and on Kielder in 1998

Two nurses who were the subject of allegations about the treatment of patients on Kielder Ward in 1998

Mr Ian Stockdale, Acting Chairman

Mrs Mary Styth, former Chairman

Mrs Jane Johnston, Non-Executive Member of the Board

Mr George McCrone, Non-Executive Member of the Board

Mr Bob Witson, Non-Executive Member of the Board

Mr Geoff Bland, Acting Chief Executive

Mr Alan Place, Chief Executive

Mr Chris Humphris, Special Projects Officer

Ms Judy Wilson, Acting Director of Mental Health (until June 2000)

Mr Chris Slavin, Acting Director of Mental Health (replacing Judy Wilson)

Mr Keith Parker, former Director of Mental Health

Mr Steve Jones, Associate Medical Director (community services) and joint clinical governance lead

Dr Chris Hallewell, Associate Medical Director (mental health services) and joint clinical governance lead

Dr Kate Porter, Consultant Psychiatrist of Old Age

Dr Alisdair MacDonald, Consultant Psychiatrist

Dr Victoria Allison Bolger, Consultant Psychiatrist

Mr David Moorat, Director of Nursing and Quality

Mr Adrian Childs, Acting Director of Nursing

Mr Bill McNulty, former Director of Mental Health Services

Mrs Catherine McCreadie, Director of Personnel

Ms Heather Burton, Locality Manager, Penrith and Eden Valley

Ms Liz Hoyle, Locality Manager, Carlisle and District

Ms Ans Epskamp, Team Leader, Old Age Psychiatry

Ms Dawn Hodgson, Acting Team Leader, Old Age Psychiatry

Ms Louise Nelson, Acting Team Leader, Adult Mental Health

Mr Mike Doak, Head Occupational Therapist

Ms Elspeth Kemp, Head of Psychological Services

Ms Anne Barlow, Training Manager

Ms Anna Burford, Public Relations Officer

Mr Tom Le-Gassicke, Community Psychiatric Nurse and newly appointed clinical governance officer

Groups of:

- local trades union representatives
- community psychiatric nurses
- social workers
- occupational therapists
- psychologists
- junior doctors in old age psychiatry
- consultant psychiatrists

The Regional Office

Mr Jim Easton, Director of Strategic and Service Development, Northern and Yorkshire Regional Office

Ms Christina Edwards, Director of Nursing, Northern and Yorkshire Regional Office

Dr Bill Kirkup, Director of Public Health, Northern and Yorkshire Regional Office

The Health Authority

Mr Robin MacLeod, Chief Executive, North Cumbria Health Authority

Mr Tony Potter, Director of Commissioning, North Cumbria Health Authority

The Primary Care Groups

Mr Paul Cookson, Chief Executive and Dr Tony Reid, Chair of the Eden Valley PCG

Mr Richard Benson, Chief Executive and Dr Stephen Thornhill, Chair of Carlisle PCG

Other bodies

Dr Horne and Dr Patterson, Carlisle Local Medical Committee

Mr Tim Watkinson and Ms Mary-Ann Bruce of the Audit Commission

Ms Pauline Lowes, Director of Nursing, Carlisle Hospitals NHS Trust

Mr Jim Rocks, Principal Lecturer in Mental Health, St Martin's College

Mr Mike Siegal, Director of Cumbria County Council Social Services

Mrs Dianne Jaffrey, Chairman External Review Panel

Stakeholders

Mrs Anne Dawson, Director, Carlisle Mind

Mrs Elaine Steven, Chairman and Mr Peter Canham, Chief Officer, East Cumbria Community Health Council

65 individuals and organisations
(see appendix C for details)

SITES VISITED

Pennine Unit, Carleton Clinic (housing patients formerly in Ward 21 and Kielder Ward)

Syra Unit, Carleton Clinic

Cedarwood Unit, Carleton Clinic

Hadrian Unit, Carleton Clinic

Oakwood Unit, Carleton Clinic

Keswick Hospital

Brampton Hospital

Penrith Hospital

Members of the investigation team also attended a meeting of the Trust Board, both the public and private sessions

ANALYSIS OF STAKEHOLDER VIEWS

The investigation team allocated three days to meetings with patients, their relatives, carers, advocates and others with an interest in services provided by the Trust, who we collectively define as stakeholders. Stakeholders also gave information by telephone and in writing. The purpose of obtaining information from stakeholders was:

- to give an opportunity for people with an interest in the Trust's services to comment on issues they believed to be relevant to the investigation
- to understand better the issues about the quality of the services in the context of local health services
- to inform discussion in the week of the CHI investigation team's visit to the Trust
- to communicate the work of the investigation team openly and positively.

Stakeholder meetings were an integral part of the investigation and the views obtained are reflected throughout the report alongside those of NHS staff and other interviewees.

Analysis

There were 65 relevant (i.e. about the Trust's services) contacts with the investigation team which resulted from a letter and accompanying leaflet which CHI circulated to 428 local organisations and individuals. The 65 responses included interviews with 12 stakeholders and, at the request of Carlisle Mind, a meeting with their members. Thirty two stakeholders made comments in writing and 20 by telephone. Some people used more than one method and several followed up contact in writing or by telephone with a face-to-face interview.

User and carer involvement

At the meeting with Carlisle MIND, concerns were raised about a lack of involvement of users and carers in services. We were told that staff did not listen to users and carers; that staff did not understand their needs; and that users and carers were not consulted about the services and needed formal involvement in Trust services, such as through a Patients' Council.

General concerns

Other issues raised by stakeholders are shown in chart 1 below :

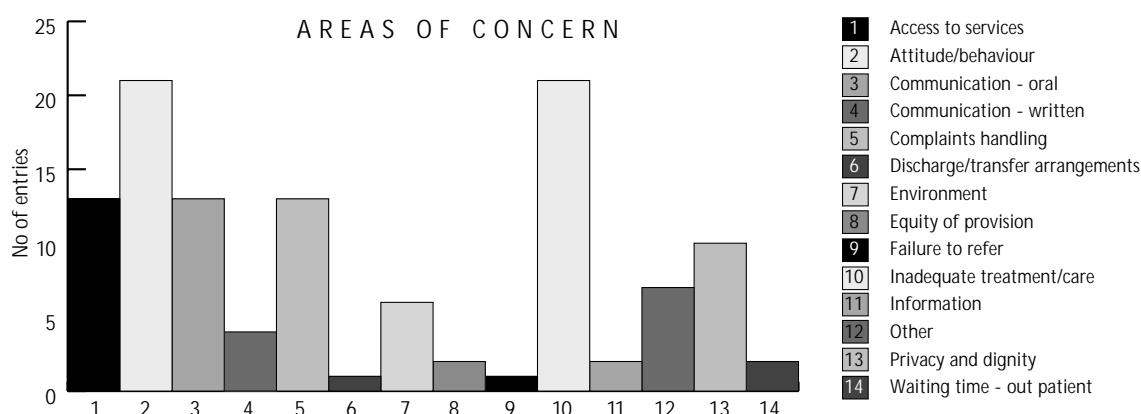


Chart 1

The main points can be summarised as:

- inadequate treatment and care – a range of concerns, including the need for more activities for patients; giving medication to subdue patients and the long wait for day case treatment
- attitude and behaviour of staff – the main complaints were about unsympathetic staff attitudes and a perceived lack of compassion
- complaints handling – the procedure for dealing with complaints was

perceived as slow and inadequate and three people claimed that their complaints had been ignored

- communication – the main concern was about the lack of information concerning the closure of a local respite facility

Comments about staff

We set out below comments about staff which we have analysed separately and displayed in chart 2.

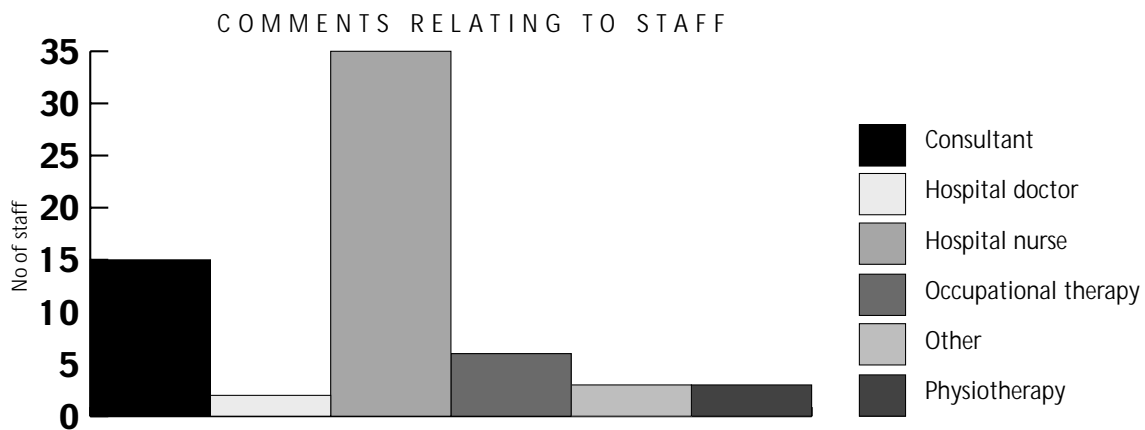


Chart 2

The main concerns about staff were:

- nursing care – we were told that there were inadequacies in the standards of basic nursing care, for example assistance with dressing, feeding and toileting, and that some nursing staff were unsympathetic to patients who required particular attention because of their vulnerability
- ineffective management – we were told that management were thought to

have been ineffective in their response to the whistleblowers

- medical management - concern was expressed about the lack of accountability of doctors for the abuse of patients which had occurred, and what was perceived as the promotion of the Consultant responsible for the abused patients to the position of Associate Medical Director (Mental Health).

NATIONAL GUIDANCE ON THE PERFORMANCE MANAGEMENT ROLE OF THE HEALTH AUTHORITY AND REGIONAL OFFICE

Guidance on the responsibilities of Regional Health Authorities and NHS Executive Regional Offices was initially set out in two Health Service Guidelines in 1994, namely HSG(94)22 and HSG(94)53. The earlier guidance (HSG(94)22) said that trust monitoring functions were to be the responsibility of the NHS Executive Regional Offices. However, when NHS trusts were set up from April 1991, a significant part of the rationale was to delegate considerable freedom of action to local level. At their inception, it was clear that NHS trusts would be monitored only against their statutory duties.

HSG(94)53 confirmed that English Regional Health Authorities were to be abolished on 1 April 1996 and (in an annex) that the functions to be transferred to Regional Offices were, 'performance/market management and policy development, this includes – agreeing and reviewing corporate contracts, purchaser/provider arbitration,

supporting national policy implementation, managing R[esearch] and D[evelopment] programmes'. In 1997, the NHS white paper, *The New NHS*¹⁹, confirmed that NHS organisations were accountable to Parliament via the Regional Offices and referred to the Regional Office role of identifying and challenging poor performance as well as promulgating good practice. The NHS Plan (July 2000) confirms and strengthens the Regional Office performance management function.

It makes clear that where NHS organisations within Regional Office jurisdiction are assessed as struggling or failing, the Regional Office must intervene to correct the situation.

The current guidance on the role of Health Authorities is given in HSC(99)192, *Leadership for Health*, which draws heavily on *The New NHS, 1997*. The strategic leadership role of Health Authorities is emphasised and there is reference to the role of the Health Authority in helping to ensure effective clinical governance. However, there is no expectation that Health Authorities will be familiar with the day to day delivery of services by Trusts.

¹⁹ *The New NHS: Modern and Dependable*

DOCUMENTS REVIEWED BY THE INVESTIGATION TEAM

The Trust and its Services

Annual Reports for 1997-1999
 Business Plan Summaries for 1998-2000
 Note on services provided from Carleton Clinic
 Site plan of the Carleton Clinic
 Trust's Strategic Direction
 Sites and bed numbers
 Local population information

The Trust's Management and Organisation

Internal correspondence on clinical and managerial arrangements
 Management and Committee structure charts
 Documents related to key management issues between 1993 and 1999
 Programmes of visits to Trust sites - 1999 and 2000

The Trust Board

Trust Board minutes - December 1998 to April 2000

1996 Trust Investigation

Investigation report and related correspondence

1998 Trust Investigation

Investigation report and related papers

2000 External Panel Review

Investigation report and related papers

Visits by Other Bodies to the Trust

Reports of visits by:
 - Independent Reference Group
 - Mental Health Act Commission

Future Reconfiguration and Management of Services

Papers relating to the consultation process and feedback

Plan for the Commissioning of Mental Health Services

Reconfiguration project brief
 Modernising the Management of the NHS in North Cumbria - a consultation document

The Trust's Complaints, Accidents and Incidents

Complaints relating to Kielder House - 1997-1999
 Summary of accidents and other incidents in Kielder House, Pennine Unit and Syra House
 Incident case histories
 Action to be taken in the event of an untoward incident

Annual complaints reports - 1998 to 2000

Breakdown of complaints by type, location and source

The Trust's Clinical Governance

Arrangements for the management of clinical governance
 Progress with clinical governance
 A strategy for clinical supervision

The Trust's Policies and Procedures

Index of policies and procedures on mental health, administration and health and safety
 Policies and procedures relating to:
 - incidents
 - complaints
 - restraint
 - personnel matters
 - whistleblowing
 - disclosure of criminal proceedings
 - disciplinary policy

The Trust's Staff

Various documents relating to:
 - trades unions
 - sickness absence levels
 - communication
 - staff attitudes
 - professional conduct
 - training
 - analysis of staffing of services

User involvement in the Trust

Various information sheets on:

- comments and complaints
- accessing health records
- the Care Programme Approach
- clinical conditions and medications

Trust Accreditation Report

Royal College of Psychiatry, approval of training report - 2000

Joint Strategic Planning

The National Service Framework for Mental Health - Implementation Plan for North Cumbria Health Authority

The National Service Framework for Mental Health - The Local Implementation Plan.

Other documents

Inspection of Social Care Services for Older People, Cumbria County Council, October 1999

The Anatomy of a Disaster, Angela Pedder, 2000

District Audit documents, including:

- Management Letters - 1998/99
- Child and Adolescent Mental Health - 1998/99
- District Nursing Services - 1998/99

Various other documents which assisted with the investigation team's understanding of the services provided by the Trust.





10th Floor, Finsbury Tower,
103-105 Bunhill Row, London EC1Y 8TG
Telephone: 020 7448 9200
Fax: 020 7448 9222
Minicom: 020 7448 9292