Report of the external review of John Meyer Ward following the death of Eshan Chattun

Commissioned by South West London Strategic Health Authority

October 2006

Review carried out by:

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1. Introduction

1.1 Why an external review was needed

- On 17 June 2003 Eshan Chattun died after being attacked by Jason Cann, a patient on John Meyer Ward in Springfield Hospital Tooting where Eshan had been working as a health care assistant. Jason was arrested and charged with murder. He was convicted of manslaughter on the grounds of diminished responsibility.

- South West London and St George's Mental Health NHS Trust (the Trust) held an internal inquiry in accordance with the Trust's Serious Untoward Incident Policy. The internal inquiry panel included members from outside the Trust: a director of Nursing Services from another Mental Health NHS Trust and an assistant director of Social Services. In addition, external advice was sought and provided to the internal inquiry from the Chattun family and their solicitor who contributed to the terms of reference. There were also involved, two consultant psychiatrists with experience in Psychiatric Intensive Care Units, an adviser on matters of race and culture and an adviser on Root Cause Analysis.

- The South West London Strategic Health Authority decided after consultations with the families of Eshan Chattun and Jason Cann that an independent external review should be commissioned. The review would not be a formal independent inquiry, but would be undertaken in the spirit of the recently amended Department of Health Guidance -HSG (94)27.

1.2 Terms of reference

The terms of reference for the external review are included as Appendix A to this report.

1.3 Who conducted the review

- The review was undertaken by Malcolm Barnard a former area director of Social Services and senior NHS manager and Pauline Neill a former director of Nursing Services, both associates of Verita. Julie Smith, Nurse Consultant, Surrey and Borders Partnership NHS Trust provided advice to the review team.

- Verita is a specialist consultancy which undertakes the management and conduct of inquiries, investigations and reviews in the public sector in the UK, including adult social care, children's services and the NHS**.**

1.4 How the review was conducted

- The Strategic Health Authority (SHA) concluded that while the issues and questions raised by the internal inquiry should prompt a further independent review, this would not be a traditional independent homicide inquiry or a re-investigation of matters looked into by earlier investigations. Instead the further work would be focused on establishing what progress had been made in implementing the recommendations of the internal inquiry and other investigations, identifying any need for further action, and on organisational learning and service improvement.

- The intention was to pursue a less adversarial, more open and collaborative approach to evaluate changes and improvements in services since Eshan's death and the subsequent investigations and focus on how work across the Trust was progressing towards modernising service models, systems and processes.

- The approach the review team developed was discussed with senior representatives of the SHA and the Trust before work began.

- The first step was to review all relevant documents including the internal inquiry report, reports of reviews and investigations by outside bodies and relevant Trust policies and procedures. Appendix B provides a list of the documentation reviewed.

- The review team then discussed the key themes identified from the documentation and produced a matrix showing for each theme the policy, organisational practice, partnership or other issues the review team wished to explore.

- The matrix also identified the people the review team needed to meet to gain a range of views and perspectives to focus on and provide evidence of implementation of change arising from the internal inquiry and opportunities for further learning and service improvement. This involved meetings, either individually or in groups, with a wide cross-section of staff from the Trust and representatives of local Primary Care Trusts.

- The review team noted that the SHA and the Trust had been in contact with relatives of Eshan and Jason and therefore considered it appropriate to ask the SHA to tell them about the review and to let them know that the review team would welcome the opportunity to meet them and hear their views and perspectives. A subsequent telephone conversation between Malcolm Barnard and Mrs Chattun confirmed that the family were happy with the review's terms of reference, which they had helped to shape. The family did not feel the need to meet the review team but would be interested to hear about the outcome. The family were particularly keen to ensure that all possible lessons had been learned to help protect staff in future.

- All the individuals and groups the review team met shared a wish to help ensure that lessons were learned from such tragedies. The review team were most grateful for the honesty and openness with which participants approached the discussions. A list of the groups and individuals the review team met is included at Appendix C.

2. Summary and conclusions

Evidence is included and discussed in the main body of the report. Recommendations appear throughout the report and are summarised in Section 12.

The overall picture to emerge from this review was of significant organisational and service delivery improvement over the past two years. This was from a starting point at the time of Eshan's death in 2003 of some major challenges for the Trust concerning governance, management, culture and practice. The willingness the review team saw and heard from staff, managers and senior clinicians within the local mental health services to identify scope for improvement and to strive to achieve it gives the review team hope that the further work identified in this evaluation will be pursued in the coming months.

- The internal inquiry was sufficiently wide-ranging. It dealt not only with the immediate questions surrounding the events of 16 and 17 June 2003 but also with the important organisational, cultural and policy contexts in which this tragedy happened.

- The internal inquiry went to great lengths to understand and determine Jason's management from the time of his admission to Jupiter Ward on 16 June 2003 to the discovery of Eshan lying unconscious in the lobby in John Meyer Ward. The panel tried to establish the deployment and whereabouts of all members of staff on duty that night on John Meyer Ward. The reactions of staff in the handling of the incident were closely examined.

- The conclusions of the internal inquiry were closely argued and consistent with the detailed analysis that preceded them.

- The internal inquiry panel's investigation was rigorous in the light of such an extremely serious incident, no matter how uncomfortable the conclusions might be for the organisation or for some members of staff.

- The recommendations of the internal inquiry were appropriate, clear and consistent with the panel's analysis and conclusions. There were, however, a few opportunities not taken to make recommendations in light of analysis and conclusions.

- Progress toward implementing recommendations since the completion of the internal inquiry report in January 2005 is reasonable. The pace of completion of work on remaining recommendations and identified actions should be expected to gain momentum in the coming months.

- The findings of the 2002 Commission for Health Improvement (CHI) clinical governance review were adequately considered by the internal inquiry but this was not always reflected in the recommendations of the internal inquiry.

- The Health and Safety Executive investigation was thorough and proportionate to the serious nature of the incident.

- The internal inquiry clearly identified failures of the Trust, even after assurances that inappropriate practice concerning seclusion had ceased, to ensure that Mental Health Act Commission recommendations were implemented.

- The review of relevant external inspections, investigations and other external involvement with the Trust confirms the internal inquiry's finding and the impression of a dislocation, at the time of the incident in 2003, between the strategic (corporate) and operational levels of the Trust.

- The level of provision from psychiatrists to John Meyer Ward has improved and is acceptable. A recent substantive appointment to the consultant post on John Meyer Ward has now been completed. This job is combined with academic sessions. Focus now is needed on developing multi-disciplinary work and accountabilities.

- In other respects the management of John Meyer Ward now appears to be well-structured and operated with a style which combines clarity of expectation with good person-centred management, sensitive to the demanding and sometimes stressful nature of the work on a PICU.

- The work, particularly over the past year, of staff and the Ward manager on John Meyer Ward to ensure that the PICU is integrated into the mainstream of the Trust's services and to identify and develop good practice is to be commended.

- The implementation of regular clinical supervision and appraisal for all staff in the Trust appears to be patchy.

- The current John Meyer Ward Operational Policy is a considerable improvement on its predecessors. It is a comprehensive policy. There are, however, ways in which it could be improved still further, building on the good work to date. An opportunity exists as part of planning for the new purpose built PICU to refine the Operational Policy.

- The Trust's present approach to surveying the patient experience is professional and systematic. It is encouraging that overall service-user satisfaction appears to be improving. The staff on John Meyer Ward are using the outcomes of questions in the surveys to help them continue to improve the services and the experience of people receiving them. The programme of evaluating user experience of services extends Trust-wide.

- The Trust's governance framework now appears to be robust and fit for purpose. It should benefit from the addition of the trust-wide Clinical Standards, Practice and Policy committee which has now been established and meetings have begun.

- The care programme approach (CPA) is not yet properly embedded in the Trust as *the* way of working. For example it is still the case that the CPA does not span the care pathways of patients, for periods in which they may be admitted to hospital or transferred to the PICU. This was identified as a problem by the Mental Health Act Commission in 2004/5.

- A patient's admission to a PICU is a very important stage in their care pathway. However, there is inconsistency, and a lack of engagement of, CPA care co-ordinators in this aspect of a patient's care.

- It appears from pilots within the Trust and in two other Mental Health NHS Trusts in England that "zoning" (reference page 62) has real possibilities to provide:
    - Consistency in the use of a core risk assessment tool across the Trust.
    - Data to assist with planning of future services.
    - Information to assist with caseload and workload management in community mental health teams (CMHT's).
    - Daily information to enable clear and detailed planning of the day on inpatient wards.
    - Dialogue with commissioners.

- The Trust's new management structure introduces both strengthening of the general management function and devolution to allow more local management of services. The new arrangements are still bedding in but there are early signs of improvement, for example in closer links between the operational and corporate functions of the Trust. Devolved, locality-based management of services needs the support of a strong, clear corporate framework. Work is underway to achieve this, but it is in the early stages.

- Developing a consistent approach to business planning across the Trust will be an important part of the corporate framework.

- The evidence the review team have seen of recent initiatives to provide a range of structured opportunities for the development of nursing practice in the Trust is commendable. The challenge now will be to ensure that the strategy and framework deliver the improvement intended.

3. A brief overview of Jason Cann's involvement with mental health services

The following background information is extracted from the internal inquiry report produced by the Trust. The internal inquiry report contains detailed chronologies of events including:

- Jason's first contact with the mental health services in South West London in 1999 when he was seventeen years old and his admissions to Springfield Hospital and the Woodside Adolescent Unit suffering acute withdrawal from long-term cannabis use with acute anxiety and borderline psychotic symptoms. The medical records reflect the possibility of Jason developing schizophrenia or post-traumatic stress disorder. He was discharged from the Woodside Unit in January 2000.

- Jason's care by the Mitcham community mental health team (CMHT) from January 2000 to July 2001. At the time of his referral to the CMHT Jason was employed as a refuse collector and was on no medication. He was assessed as at "low apparent risk" by his community psychiatric nurse (CPN) on 21 January 2000. In October 2000 Jason was prescribed risperidone, an anti-psychotic drug, but did not attend follow-up appointments with his CPN or his consultant psychiatrist. The CPN visited Jason at his flat in December 2000. Jason had made good progress, was enjoying his job, had drunk alcohol for two months and had not used illicit drugs. It was agreed to discharge him from the care of the CMHT in the New Year. There was no contact between Jason and the CPN until 2 April 2001 when the CPN visited for a booked appointment but Jason was not at home. The CPN wrote to Jason asking him to make contact by 1 June and indicating that if no contact was made he would be discharged. The CPN wrote to Jason's general practitioner (GP) on 6 July 2001 informing him that Jason had been discharged.

- There was no further contact with the mental health services until Jason's admission to Jupiter Ward at Springfield Hospital on 15 June 2003. Jason's girlfriend had called the police to their home as he had been preventing her from leaving and exhibiting unusual behaviour, such as talking in a different voice and not recognising her. The police took him to Jupiter Ward, an acute admissions ward, for assessment of his mental state. Jason absconded from Jupiter Ward

twice on the day of his admission. It had been decided that he should be detained under the Mental Health Act for further assessment and transferred to John Meyer Ward, the psychiatric intensive care unit (PICU) but Jason left the ward unnoticed before the transfer could take place. Police found him at his home the next morning and he was taken without resistance to John Meyer Ward under Section 136 of the Mental Health Act.

- An assessment of Jason's mental state was undertaken by a senior house officer during which Jason admitted having used cannabis occasionally and having taken crack cocaine a few days previously. He also said he had consumed four or five cans of lager although it was not clear how recently. The initial medical assessment suggested that Jason was experiencing a hypomanic or manic or mixed affective state. The plan was for him to be assessed for detention under Section 2 of the Mental Health Act, which makes provision for the individual to be detained for up to 28 days.

- Assessment under Section 2 of the Mental Health Act followed in the afternoon of 16 June 2003. Jason admitted polysubstance abuse. He described being violent when intoxicated and using weapons, mainly knives. He reported persistent hallucinations, being commanded to take drugs and alcohol and to harm people and hearing voices. The clinical impression from the assessment was that Jason was experiencing a paranoid psychosis, fluctuating in the context of severe polysubstance dependence. It was recommended that he be detained under Section 2 of the Mental Health Act. Regular medication was prescribed, as was the use of rapid tranquilisation, if required, as part of his care and risk management plan. A comprehensive risk assessment was carried out at this time and incorporated into his care plan.

- After the assessment the approved social worker (ASW) took Jason into a separate room on his own and explained that he was to be detained in hospital. Jason assaulted the ASW, knocking him to the ground and grabbing him by the throat but releasing him spontaneously. The nursing staff were alerted when the ASW called for help.

- The decision was taken immediately after this incident to place Jason in seclusion. He was also given oral medication. Jason was taken to one of the two designated seclusion rooms on the ground floor in John Meyer Ward and observed from an adjacent viewing room. He was in seclusion from 15.40 to 16.50 when the decision was taken to move him from it. He was moved to the lobby corridor where he fell asleep after supper.

- During the medication round sometime after 22.00 hours Jason, who remained downstairs, declined to take his regular prescribed medication. Jason and another patient who had been in the second seclusion room were moved upstairs just after 23.00 hours. A further attempt was made to persuade Jason to take his regular prescribed medication. Once upstairs, Jason again became agitated and unsettled. The duty senior nurse (DSN) was contacted and asked to go to the ward. The DSN contacted the emergency team and asked them to go to the ward as he expected to need their help in managing Jason.

- The emergency team arrived on the ward and the DSN discussed the situation with the staff nurses on duty. Rapid tranquilisation medication had been prepared for Jason. The DSN suggested that Jason should be moved downstairs again because he had been quieter there. The transfer was undertaken by three health care assistants (HCA's). The DSN joined them downstairs. Jason was singing to the effect that he wanted to go home and performing what were described as "tai chi" movements. The DSN considered that Jason was more settled and did not think it necessary to use compulsory medication as allowed under the Mental Health Act. One of the HCA's, Eshan Chattun remained downstairs with another HCA observing Jason who was locked in the lobby corridor, from the widow of the ground floor nurses' office. One other HCA was also downstairs for a time.

- Just before midnight Jason had still not settled and was described by the HCA's as performing "martial arts" movements. At around this time one of the staff nurses telephoned to ask the other two HCA's to return to help with patients upstairs, leaving Eshan alone observing Jason from the nurses' office. At one point the staff nurse telephoned Eshan to check that everything was under control and the staff

nurse subsequently reported warning Eshan again not to enter the lobby corridor alone.

- During the period between approximately 00.00 to 00.20 hours on 17 June 2003 Eshan remained downstairs alone, observing Jason. The staff nurse subsequently reported that during this period she telephoned Eshan and heard noise. Eshan had told her that Jason was performing martial arts. The other staff nurse also reported that she had also telephoned Eshan at some point to check what was happening.

- At about 02.15 hours one of the other HCA's was alerted to different noises from downstairs. He went to the upstairs nurses' office and telephoned Eshan to check what was happening but there was no reply. He telephoned again immediately but again with no reply. He went downstairs and from a small window leading into the lobby he could see Jason who appeared to be breathless and agitated. He could also see blood on the floor. He went upstairs and en route alerted another HCA. They returned downstairs together via stairs at the other end of the ward and entered the downstairs nurses' office where they had a better view of the lobby corridor. Eshan was not in the nurses' office and the door from the office to the lobby was shut. They were still unable to see Eshan but from a window in the door between the lounge and the lobby corridor they saw Eshan on the ground with blood coming from his head.

- One of the HCA's called the emergency team at 02.30 stating that there was a psychiatric emergency. This was followed by a second call at 02.32 stating that there was a medical emergency. The emergency team responded within minutes.

- The DSN arrived first on the scene and took charge of restraining Jason assisted by three health care assistants, two from the emergency team and one who was on duty on John Meyer Ward.

- The duty senior house officer arrived soon after the DSN and immediately went to attend to Eshan. The SHO described Eshan as having severe head and facial injuries. He had no pulse and was not breathing. He called for the resuscitation equipment and with the help of a HCA began cardio-pulmonary resuscitation. The SHO called the ambulance service and returned to take over resuscitation.

- The paramedics and the police arrived together five minutes after being called. The paramedics took over resuscitation and then took Eshan to St George's Hospital Accident and Emergency Department where he died.

- The police took over restraining Jason and moved him to one of the adjacent seclusion rooms. He was arrested and taken to the local police station, from where he was transferred to Brixton Prison and later to Broadmoor Hospital where he remained until his trial.

4. Review of the internal inquiry report

4.1. Overview

- The report of the internal inquiry commissioned by the South West London and St George's Mental Health NHS Trust was dated January 2005. It is the well-written and well-presented report of a commendably comprehensive and robust internal investigation; a proportionate response to a serious and tragic incident. The report helpfully included highlighted "key issues" boxes throughout to draw the reader's attention to important matters and to summarise key points.

- Chaired by a non-executive director of the Trust, the internal inquiry panel included appropriate membership drawn from senior management and senior clinicians within the Trust and in addition included a director of nursing from another NHS Mental Health Trust and an assistant director of Social Services. The panel also sought external advice from the Chattun family and their solicitor about the terms of reference and from two consultant psychiatrists with experience in PICU's, an adviser on matters concerning race and culture and an adviser on Root Cause Analysis.

4.2. The context and scope covered by the internal inquiry

- The terms of reference were appropriate, particularly with the inclusion of important additional areas for consideration suggested by the Chattun family through their solicitors.

- The membership of the internal inquiry panel included people with sufficient qualifications and expertise and of sufficient seniority to fulfil the terms of reference. External expertise and advice were sought and provided where necessary.

- The internal inquiry report fully described the process of the inquiry and included a comprehensive section on "Setting the Scene". This included a history of John Meyer Ward and a profile of the ward environment and helpful contextual information on the backgrounds of Jason Cann and Eshan Chattun. A detailed description of the events leading to Eshan's death followed and events following the incident and the Trust's response were then reported upon. Cross references had been made in a preceding chapter with other investigation processes with particular reference to the police investigation and criminal justice process, the Coroner's Inquest, the Health and Safety Executive "Death at Work" investigation and the requirement for an external inquiry subsequent to the internal inquiry. An equally full and comprehensive section of the report was devoted to the "Outcomes of the Inquiry". It provided a detailed account of the analysis and findings of the internal inquiry panel and clearly set out the panel's conclusions and recommendations. The final section of the report concerned "The Learning Organisation". It described a number of inspections by outside bodies and relevant recommendations from them and set the need to learn from such a tragedy in the context of action that had already been taken by the Trust at the time of the report's publication and of emerging themes from the inquiry and their integration with the Trust's Clinical Governance Plan and work with commissioners to support improvements in the quality of services.

Comment

The internal inquiry was sufficiently wide-ranging. It dealt not only with the immediate questions surrounding the events on 16 and 17 June 2003 but also with the important organisational, cultural and policy contexts in which this tragedy happened.

4.3. The internal inquiry's analysis

- The findings outlined in the chapter on "Analysis and Findings of the Inquiry Panel" were drawn from witness statements and evidence, knowledge of the Trust from internal members of the panel and expertise from external panel members and advisers. The analysis adhered to the internal inquiry's terms of reference. In addition it appropriately included other factors identified as influencing the performance of front-line staff delivering clinical services, including the management framework supporting clinical services, the management of John Meyer Ward, management in the General Adult Services Directorate, corporate management through the Trust's executive team and overall performance management of front-line staff.

- Key issues were appropriately highlighted in shading in the presentation of this section of the report. This draws the reader's attention to particular matters of importance, for example in relation to instances of good and poor exercise of professional and clinical judgement and the inconsistent quality of the relevant policies and procedures.

- The report sets out in detail the panel's findings in establishing the events leading up to Eshan's death.

Comment

It is clear that the internal inquiry panel went to great lengths to understand and determine Jason's management from the time of his admission to Jupiter Ward on 16 June 2003 to the discovery of Eshan lying unconscious in the lobby area in John Meyer Ward. The panel had also clearly tried to establish the deployment and management of all the staff on duty on John Meyer Ward that night and where each member of staff was at the time of the incident and in the preceding period. They had also closely examined the reactions of staff in handling the

incident. The analysis was thorough, facilitated the identification of key themes and learning points and enabled the formulation of relevant and important conclusions and recommendations.

4.4. Conclusions of the internal inquiry

- A number of conclusions have already been identified in the analysis section of the report (see above).

- The conclusions section of the report described in detail the conclusions reached by the panel. Conclusions were grouped appropriately under a number of headings:

    - Events on the night of 16/17 June 2003
    - Clinical judgements; professional and clinical leadership
    - Organisational culture
    - Definition of the role and function of psychiatric intensive care in the trust
    - Quality of the physical environment of John Meyer Ward
    - Management arrangements
    - Ward level implementation of policies and procedures
    - Human resources policies and procedures
    - Training for staff
    - Management of the hospital at night

- Systems for supporting front-line staff delivering clinical services
- Responding to emergencies
- Performance management

Comment

The conclusions of the internal inquiry were closely argued and consistent with the detailed analysis that preceded them.

The internal inquiry panel's investigation was rigorous in light of such a serious incident, no matter how uncomfortable the consequent conclusions might be for the organisation or for some members of staff.

4.5. The internal inquiry's recommendations

- The panel made 23 recommendations. They were again helpfully grouped under the headings used to group the preceding conclusions (see above).

- The recommendations were appropriately wide-ranging - across training, practice, supervision, policy, management and organisation - and addressing issues from ward level to Trust Board.

Comment

The recommendations of the internal inquiry were appropriate, clear and consistent with the panel's analysis and conclusions. There were, however, a few opportunities not taken to make recommendations in light of analysis and conclusions (See Para. 4.7. below):

4.6. Immediate actions

Commendably, the Trust did not wait until the internal inquiry was commissioned or had reported to address the immediate issues as they were identified.

- On the morning of 17 June 2003 the chief executive gave the instruction to close John Meyer Ward and transfer patients to alternative locations. There was nowhere on the site where the PICU could be re-housed in its entirety, so a number of alternatives were promptly identified. All patients on John Meyer Ward at the time were reviewed and in accordance with the outcome of individual reviews they were transferred either to the Shamrock Unit, another PICU within the Trust at Tolworth Hospital, or to Hume Ward, a minimum secure forensic ward on the Springfield Hospital site. Patients assessed as clinically well enough were transferred back to their originating ward. Four beds in the private sector were also commissioned for psychiatric intensive care.

- Arrangements were made to liaise with and support Eshan's family and to engage with Jason's family.

- By July 2003 the Trust recognised that maintaining a combination of a minimum secure service PICU and Section 136 facilities together on Hume Ward was not sustainable. The decision was taken to transfer all forensic patients from Hume Ward to appropriate private sector beds, leaving Hume Ward as the temporary PICU facility.

- The Trust began the process of considering the future re-provision of the PICU service from John Meyer Ward immediately after the incident. The Trust Board set up a group chaired by the director of planning to explore the options for the long-term future for PICU accommodation. The outcome of the option appraisal was that in the medium term, despite its environmental shortcomings, John Meyer Ward remained the most suitable accommodation available. None of the alternatives was appraised as safer or more suitable.

- The Trust Board decided that a further review of the safety and viability of John Meyer Ward for re-use as a PICU should be undertaken. The John Meyer operational group was established to undertake this work, chaired by the clinical director of the adult directorate. The group included in its considerations emerging findings from the internal inquiry and the investigation by the Health and Safety Executive. The group concluded that the use of John Meyer Ward was the most viable option in the short to medium term.

- The Board agreed on the basis of the report from the operational group to re-commission John Meyer Ward. The decision was taken "subject to securing the safety of the service".

- The internal inquiry report describes as follows a number of key issues addressed by the John Meyer Ward operational group which continued its work looking particularly at the safety issues:

    - "A comprehensive review of the Operational Policy for the ward and its associated policies and procedures.

    - Changes to the staffing skill mix to enhance the proportion of professionally trained nursing staff and increase input from other professional disciplines.

    - Changes to the clinical management structure to bring about a strengthening of leadership on the ward.

    - Mandatory training, including "breakaway" techniques and "control and restraint" training; a comprehensive induction to the ward and a two-day induction to operating policies and procedures set out in the new Operational Policy.

    - A separation of the Section 136 facilities to provide an area separate from the PICU service.

- Refurbishment of the ward environment and various design changes including a reduction of beds from 12 to 10.

- Establishing the ward as single sex (male only, with females being admitted to the Shamrock Unit)

- Installation of a CCTV system in all areas of the ward which would be subject to 24-hour monitoring."

- The PICU at John Meyer Ward became operational after refurbishments as a 10-bed male-only service in May 2004.

- Further work streams were put in place from May 2004, partly in response to the incident but also in response to the earlier CHI clinical governance review. They were encompassed in a "Service Development Programme" for the Trust as a whole.

- The Trust discussed the long-term provision of the PICU service with the South West London Strategic Health Authority after the incident. Work on the business case and to secure capital funding has been proceeding since. The proposal has the support of the Primary Care Trusts (PCTs). It is expected that final approval to the project will be given before the publication of this report and that a new PICU on the Springfield Hospital site could be open by 2007.

Progress in improving the service in John Meyer Ward since it re-opened is discussed in Section 7 below.

4.7. Gaps in and issues for debate from the internal inquiry

The report of the internal inquiry was clear, robust and comprehensive but it would be surprising if a thorough external scrutiny did not identify any gaps in the issues identified or in analysis. It would be equally surprising if some conclusions,

recommendations and their implementation were not questioned following the changes introduced since the incident. (It is accepted that some of the specific points below may have been intended by the internal inquiry to be covered by more general conclusions and/or recommendations, for example the review of the John Meyer Ward Operational Policy). This sub-section identifies such gaps and issues in the order in which they appear in the internal inquiry report:

- In para 4.29 and recommendation 12.6 of the internal inquiry report staffing arrangements for John Meyer Ward are considered. The recommendation states that staff working on the PICU units should not be newly qualified. There are no national set guidelines for skill-mix in mental health settings. However, national PICU implementation guidelines state "Psychiatric Intensive Care is delivered by qualified staff". The National Association of PICUs (NAPICU) network generally acknowledges that Grade D (newly-qualified) Nurses are appropriately employed within PICUs. The progress towards implementing this recommendation is commented upon further in Section 5 below which deals with a review of progress in delivering the action plan agreed by the Trust to monitor and review implementation. In practice a small number of newly-qualified (Grade D) nurses working in PICU's can be a positive part of the skill mix, subject to robust induction, preceptorships, clinical supervision and skills development. They can bring fresh eyes, innovation, evidence-based practice and appropriate challenge to the ward team. Care is needed to ensure that when staff start work they have the necessary core skills and competences. This has been achieved in practice on John Meyer Ward (post the completion of the internal inquiry report) through the employment of newly qualified staff – most of whom had already completed practice placements as students on John Meyer ward.

- Para 5.5 and paras 10.283 and 10.284 of the internal inquiry report dealt with Jason's history of racially-motivated violence. This could have been followed up in the report with a conclusion and recommendation about the development of a flagging system for staff groups at risk of aggression or violence from individual patients because of their gender, race, religion or

sexuality. In turn, that could have led to conclusions and recommendations regarding the monitoring of incidents of aggression and violence against staff from ethnic minorities.

- It was surprising that no conclusions or recommendations were reached or made concerning the audit and monitoring of violence and aggression, or concerning the use of seclusion and rapid tranquilisation and compliance with the Care Programme Approach (CPA).

- Skills and training for control and restraint and breakaway techniques are discussed in paras. 6.7 and 10.184 of the report. A conclusion in Para. 11.43 was that staff on John Meyer Ward and the emergency team were not required at the time of the incident to have training in control and restraint and managing violence and aggression. The internal inquiry made general recommendations concerning mandatory training, training for health care assistants, policies and procedures and skill mix and competencies. However, there was no specific recommendation about control and restraint and breakaway training and competencies or about the link between these essential skills in such a high- risk environment and successful compliance with the seclusion policy.

- The report clearly identified the poor practice and performance of some staff. There appeared to be some inconsistency, however, in the way that was handled in the recommendations. A recommendation was included concerning the need for a review of the competencies of the three qualified nurses responsible for John Meyer Ward and the Springfield Hospital site on the night of the incident. That recommendation was appropriate in light of the earlier evidence. However, in Paras 10.246 to 10.252 and 11.12 the report had also identified poor performance of the clinical team leader, stating: "Having knowledge of this unsafe practice (the multi-purpose use of the lobby)the clinical team leader should have taken action to ensure such practice ceased as soon as she became aware of it". Yet no recommendations were included regarding actions to address the performance of the consultant psychiatrist in this post at the time. Nor was

there a recommendation specifically aimed at improving the multi-disciplinary approach to the management of the ward, although a more general review of the management arrangements for John Meyer Ward was recommended.

- In Para 10.8 the report identified Jason's absconding from Jupiter Ward as having laid down a marker for the unpredictable nature of his behaviour. There appears to be no connection made between this concern and the sharing of information on risk assessments when patients are transferred between Wards. There appears to be no follow up later in the report regarding monitoring and reporting of absconding by admission wards.

- The volatility of the situation on the Ward on the night of 16 June 2003 was highlighted in Para 10.30. The subsequent paragraphs deal in detail with matters concerning the deployment and management of staff up to the time of the incident. But an opportunity was missed to examine or draw attention to the need for a policy to guide staff on the need to call for medical attendance and advice when the ward is particularly volatile.

- It is not clear from the report whether standards were in place for on-call staff attending incidents, for example expected response time from receiving the call to arrival on the ward.

- The report dealt in Paras 10.32 and 10.33 with an allegation that the decision to allocate Eshan to the shift was influenced by family relationships. The panel was not able to substantiate this but noted that the rotas were muddled. This was commented upon further in Paras 10.111 to 10.113. A conclusion in Para 11.15 stated: "The negative culture was supported by informal networks that operated more powerfully than the formal management and communication systems-------. These informal social systems need to be acknowledged and effectively managed." This was a reasonable conclusion based on the evidence. There were, however, no specific recommendations concerning the management of staff rotas or policy regarding relatives working together in closed environments.

- The handover arrangements between shifts on the evening of 16 June 2003 were dealt with in paras 10.38 and 10.41. It was reported that not all staff were present for all of the verbal handover report. No specific reference was made in the conclusions section of the report or in the recommendations to the vital importance of full attendance at handover meetings, particularly in view of the changing risk assessments of patients on a PICU.

- Decision-making about staff deployment and who should observe the patient downstairs was considered in para 10.45. But this does not appear to have been followed through in the report with an appraisal of the deployment decision in light of any protocol or Operational Policy in place at the time to guide such decisions.

- Some significant linguistic difficulties between staff and possibly between staff and patients were highlighted in Paras 10.263 to 10.265. The richness of experience brought to the service by the diversity of staff had also been appropriately emphasised. However, neither of these factors featured in the conclusions or the recommendations of the report. Communication and linguistic skills could have been identified as key competencies for nurses and health care assistants. There was no reference to the need for work in the Trust towards improving equality and diversity. A strategy for this could include addressing the issues described immediately above. (See also Para 7.5. and recommendation 11 below).

Recommendation 1

The Trust should consider the gaps and issues for debate in the internal inquiry report identified (above) in this review to establish whether they have been addressed since the internal inquiry and, where they have not, ensure that appropriate action is put in place.

5. Action plan and implementation of recommendations

5.1. The action plan

We reviewed the latest available updated version, dated 14 February 2006, of the action plan the Trust developed in response to the internal inquiry report. The Action Plan lists all 23 recommendations and sets against each: the action required (response), accountable officer (lead director), target (due) date, and current position. There is, however, no space for recording of or cross reference to evidence of actions completed.

The format of the action plan is confusing. Some recommendations are listed several times, depending on which part of the recommendation is the responsibility of which lead director. Some recommendations are paraphrased and some are broken down into component parts. It is therefore difficult for the reader to grasp easily which recommendations have been fully or partly implemented.

Recommendation 2

The Trust should consider adding a column to its format for action plans to record evidence of completed actions. Further improvements are needed to the format to ensure that action plans are effective monitoring tools to enable the recording and continuous review of actions until they are signed off, with evidence of completion recorded.

5.2. Implementation of the recommendations of the internal inquiry

The following commentary identifies from the review of the action plan and fieldwork meetings the present position on the implementation of the recommendations of the internal inquiry. Some brief comments are provided on overall progress towards implementation.

- No entry is included in the action plan update January 2006 for recommendation 12.20 concerning training for health care assistants (HCA's) in

their role. However, action to meet this recommendation through modular NVQ-based training is included in the Trust's Nursing Strategy approved by the Trust Board on 26 April 2006. A review date for the completion /review of this action is given as 2007/8. The review team regard the implementation of this internal inquiry report recommendation to be "work in progress" and would hope to see some early progress over the next few months towards addressing priorities in supporting HCAs in achieving core competencies.

- Of the remaining 22 recommendations, substantial progress has been made towards implementation. Only seven appear to have been completely implemented. A further 12 have been partially implemented and work is active on the remaining three.

Comment

Progress towards implementing recommendations since the completion of the internal inquiry report in January 2005 is reasonable. The pace of completion of work on remaining recommendations and identified actions should gain momentum in the coming months.

More detailed discussion of progress on the key themes that emerged from the internal inquiry is provided in Sections 7 to 11 below.

6. Review of reports from outside agencies

Our terms of reference required the review team to review changes on John Meyer Ward in light not only of the Trust's internal inquiry but also of earlier investigations including the Commission for Health Improvement (CHI) clinical governance review, the Health and Safety Executive "Death at Work" Investigation, reports of Mental Health Act Commission visits and other relevant information.

The internal inquiry report recognised the need to reflect and learn from the outcomes of inspections by a number of outside agencies. Chapter 13 of the report was devoted to reviewing the outcomes of those inspections relevant to the tragic events of 16 and 17 June 2003. The review team do not intend to repeat the thorough work of the internal inquiry in this respect.

This section therefore provides a brief overview of relevant investigations, reviews and reports, comments on their interface with the Trust's internal inquiry and identifies key themes and issues with cross references to later sections of this report.

6.1. The commission for health improvement (CHI) Clinical Governance Review February 2003

The CHI Review, conducted in late 2002, looked at clinical governance in older people and adult services. It concluded that the Trust had a structural framework for clinical governance and quality improvements. However, it needed to improve the links between the different clinical governance components. Systems for shared learning and local implementation in clinical teams required further development. The Trust was found to be engaging service-users and carers at every level in the organisation to obtain views to improve services. However, the Trust should further integrate the needs of carers into its work. The review found service-users to be appreciative of the friendliness and commitment of staff and that staff worked extremely hard to provide services despite short staffing and poor physical environments in some inpatient areas. A number of areas of notable practice were identified including the development of the early intervention team, the assertive (outreach) community team and an eight-

bed women's unit to meet the needs of vulnerable women and those requiring single sex accommodation.

- The CHI review also highlighted a number of areas for action by the Trust to improve its clinical governance systems. These included:

- Urgent action to improve (the physical environment) of inpatient wards.

- An urgent and comprehensive review of security with implementation of changes to ensure safety and security on inpatient sites.

- Action to improve communication and visibility of corporate management across the sites.

- Improving sharing of best practice and lessons learned across the Trust.

- Continued development, harmonisation and implementation of information systems to enable clinical teams to use information to improve services and practice.

In its assessment of the Trust's systems for risk management CHI flagged up a number of issues for consideration, including:

- Close monitoring and evaluation of the implementation of its resuscitation policies.

- Review of seclusion facilities against the Mental Health Act code of practice standards.

Areas for improvement in the Trust's systems for clinical audit were also identified. They included:

- Continued increase in multi-professional audits across the Trust and with external partners.

- Improving integration of audit with other components of clinical governance.

- Increasing the uptake of skills training in evidence-based practice.

The internal inquiry report made the links between its work and the CHI review. In addition to the issues summarised above, the internal inquiry report also referred to the CHI findings concerning monitoring and evaluation of supervision models and consideration of ways to increase and monitor the uptake of educational courses and mandatory training.

Comment

The findings of the CHI Review were adequately considered by the internal inquiry but this was not always reflected in the inquiry's recommendations.
(See also Paras 4.5 to 4.7 above).

6.2. Health and Safety Executive "Death at Work" Investigation and assessment of structures across the Trust

The internal inquiry report referred to the planned visit to the Trust by the Health and Safety Executive (HSE) on 23, 24 and 25 September 2003, three months after Eshan's death, to carry out an inspection in accordance with the Health and safety at Work Act 1974. The inspection specifically covered: manual handling, managing violence and aggression and "any other matters drawn to the HSE's attention." Following the visit the Trust were served with three improvement notices for: training in the management of violence and aggression, lone worker policy and training of estates staff.

We had helpful discussions with Margaret Pretty, principal inspector, HSE, Hazel McCullum and Kerry Williams who were inspectors involved with the follow-up to the incident on John Meyer Ward. Bernardine Cooney who led the post-incident HSE investigation was no longer working for the HSE in London.

The meeting confirmed that:

- The incident was reported to the HSE promptly.
- The HSE investigation started on the day of the incident.

The HSE investigation report dated 4 March 2004 confirms that Ms Cooney's first visit to John Meyer Ward was on 17 June 2003. Visits were made on a further 21 dates between 18 June 2003 and 31 March 2004. Thirty seven people were seen by the HSE during the investigation, mostly employees of the Trust, including staff on duty on John Meyer Ward at the time of the incident and managers at all levels in the Trust. Other people interviewed included police officers and the Coroner's Officer.

Comment

This was a thorough investigation, proportionate to the serious nature of the incident.

At the meeting with the HSE Inspectors it was confirmed that concerns at the time of their planned inspection in September 2003 were sufficiently serious to warrant them issuing three improvement notices. The Trust was given an extension until March 2004 to comply with the notice concerning lone-worker policy.

The HSE as Crown Prosecutors took the decision to prosecute the Trust having examined the evidence. Tests of evidence and of public interest are applied before such prosecutions proceed. The Trust admitted breaches in its responsibilities as an employer. The prosecution under Section 2 of the Health and Safety at Work Act 1974 was successful and the Trust was fined £28,000.

The review panel met with the HSE and with trust managers including a risk manager. The risk manager had responsibility to oversee the work of the health and safety consultants who manage health and safety systems for the hospital. The review team concluded that a focus within the Trust on clinical risk, could compromise the attention paid to non-clinical risks, particularly on a large site like Springfield Hospital containing many old buildings.

Recommendation 3

The Trust should review its arrangements for managing health and safety systems and consider appointing a qualified Health and Safety manager to strengthen its overall structure for risk management.

6.3. Reports of Mental Health Act Commission visits

Visits by the Mental Health Act Commission to the Springfield Hospital site in December 2000 and January 2003 are described in the internal inquiry report. Concerns about practices concerning seclusion of patients had been raised and the report of the December 2000 visit recommended that the Trust review the practice of isolating in the designated "quiet rooms" on John Meyer Ward patients who exhibited disturbed behaviour and ensure that seclusion policies and procedures were adhered to for the protection of both patients and staff. As part of the Trust's formal response to the report, the chief executive stated that since mid-December 2000 all patients requiring seclusion had been managed in strict accordance with the Trust's seclusion policy. Nonetheless, during the January 2003 visit the Mental Health Act Commission again expressed concern that conditions for seclusion on John Meyer Ward did not meet the Mental Health Act Code of Practice guidance. The issues around seclusion and the position in 2006 are considered further in Section 7 below.

Comment

The internal inquiry clearly identified failures of the Trust, even after assurances that inappropriate practice concerning seclusion had ceased, to ensure that Mental Health Act Commission recommendations were implemented.

The subsequent Mental Health Act Commission Annual Report on the Trust for October 2004 to October 2005 made a number of references to and comments upon visits by Mental Health Act Commissioners to John Meyer Ward in that period, including comments on:

- Excessive reliance on CCTV as a method of ensuring the safety of staff and patients - (Extensive CCTV had been installed before the Ward re-opened - the Trust recognised that use to this extent was not appropriate. It is no longer used on the ward except for observation of the seclusion room and alternative uses elsewhere have been identified.)

- Lack of meaningful activities for patients.

- Its opportunity to comment on the new Operational Policy.

- The building's unfitness for purpose.

- The continued use of two floors for the operation of the Ward. (This had changed to operation on one floor only by the time of publication of the Commission's report).

- The decision not to open the Section 136 suite on the unit - seen as a positive decision by the Commission.

A number of other comments observations and recommendations of relevance to the review were made in the Commission's 2004/2005 report concerning services in the Trust as a whole. These included:

- Use of seclusion.
- Application of the Care Programme Approach (CPA) for in-patients.
- Physical environment.
- Staffing issues.
- Ethnic, cultural and religious issues.

6.4. Other Relevant Information

We were advised by the Strategic Health Authority that the Trust's chief executive had sought advice on security matters from the NHS Counter Fraud and Security Management Service (CFSMS). The review team met Rick Tucker, head of Security Management, Mental Health and Learning Disability at the CFSMS. Mr Tucker had previously held the post of mental health lead at the Nursing and Midwifery Council and in that capacity had provided external scrutiny and review of the new Operational Policy for John Meyer Ward. Mr Tucker explained that after his arrival at CFSMS he had met the chief executive to discuss a possible support package for the Trust. There had been a history of co-operation and mutual working between the Trust and CFSMS. The next step was to be a meeting between himself, the Trust's chief executive, the director of nursing, another nurse manager and the director of planning. However, this took a long time to arrange, apparently because the Trust's senior managers were busy. The meeting was held in the summer of 2005 but the Trust's managers seemed unprepared. The CFSMS did however offer support in: looking at training provision, meeting with front-line staff, contributing to education programmes and presenting seminars and workshops. Since then there have been two or three days when the Trust has asked the CFSMS to contribute.

In December 2003 the secretary of state launched a new strategy for security management work in the NHS. A key part of the strategy was the designation in each NHS body responsible for mental health services or services for people with learning

disabilities of a local security management specialist (LSMS). The strategy also referred to the nomination of a director responsible for security management in all such NHS bodies. This initiative was taken in response to widespread threatened and actual violence against staff which was of varied causes and inconsistently reported.

Recommendation 4

The Trust should review its arrangements for managing security, including designating a local security management specialist (LSMS).

Comment

Our review of relevant external inspections, investigations and other external involvement with the Trust, confirms the internal inquiry's finding and the impression of a dislocation at the time of the incident in 2003 between the strategic (corporate) and operational levels of the Trust.(Progress towards addressing and overcoming that major problem is discussed further in Section 11)

7. John Meyer Ward 2006

We visited John Meyer Ward twice during the review and met the ward manager and general manager responsible for it and the borough director for Wandsworth who now has senior management responsibility for the ward. The review team also met a number of ward staff in three small groups, including a group of health care assistants.

Our purpose was to assess and review progress in delivering improvements for patients and staff on John Meyer Ward since it reopened in May 2004. (The processes of re-commissioning John Meyer Ward as a PICU were described in para 4.6. above)

7.1. The physical environment

- Since refurbishment and re-opening in May 2004 the patient area of the ward, except the garden, is now situated on the first floor. Some office accommodation and a meeting room are still in use on the ground floor. This means that the previous problems of managing the unit over two floors, including managing the risks of transferring patients between two floors, no longer exist, except with regard to use of the garden for which clear procedures are in place.

- Inevitable wear and tear have taken their toll in some areas since the refurbishment for example in the smoking room, the day area and the seclusion room.

- The building remains unsuitable for a modern PICU service.

- The situation of the seclusion room, although it is away from the day area, is far from ideal, but there appear to be no short-term solutions to this problem (See also Para.7.4)

- The response to requests to the Estates Department for essential repairs may be too slow. For example review team saw damage to the plaster round the

door frame in the seclusion room which was still awaiting repair a week after the damage had been reported.

- At the time of writing Trust Board and the PCT's have approved the business case for a purpose-built PICU on the Springfield Hospital site, (as part of a larger suite for inpatient and community mental health services to serve Wandsworth). Final approval from the SHA has now been granted.

Recommendation 5

It is essential that the re-provision of the PICU on the Springfield Hospital site is commissioned and completed as soon as possible.

Recommendation 6

The Trust should audit and review response times from its Estates Department to requests for repairs in areas where patients may be at high risk.

Recommendation 7

Pending the completion of the new purpose-built PICU consideration should be given the need for short-term improvements to the present ward environment, for example through the use of colours in the décor and of light and space. (The King's Fund "Enhancing the Healing Environment" programme and the NHS Estates "Art of Good Health" series offer some useful advice.)

7.2. Management and leadership of the ward

- The ward reopened in May 2004 and there was a period of seconded or acting ward managers. A permanent ward manager took up the post in April 2005. The new postholder was an experienced ward manager, highly regarded by senior managers in the Trust. The ward manager now reports to the general manager for the North Sector in the Wandsworth Borough Directorate. The postholder moved into his current post in 2004. He had five years' experience as a service

manager elsewhere in the Trust. The Trust saw the need to transfer an experienced manager to the post in view of the responsibilities to oversee and maintain improvements in the PICU service at John Meyer Ward and to contribute to the work on planning the replacement PICU. The general manager reports to the borough director Wandsworth and serves as a member of the Borough Executive (senior management team). It was clear from the fieldwork meetings that the borough director has taken a close personal interest in the progress of the service on John Meyer Ward since taking up his appointment in early 2005.

- Three deputy ward managers are now in place. These appointments have allowed the delegation of some responsibilities, for example for duty rotas, lone- working policy and health and safety. The deputies have also enabled and supported the clinical supervision arrangements for the Ward (See also para. 11.4. below).

- Nurses attend weekly ward meetings. They include regular discussion of the ownership, implementation and compliance with policies and procedures.

- A locum consultant psychiatrist has been providing cover for the ward as 0.8 whole time equivalent (WTE). This is 0.3 WTE above the establishment for the substantive consultant post. The present locum has been in post since March 2006. The recruitment process for the appointment of a substantive consultant psychiatrist (associate specialist) with 0.5 WTE devoted to the PICU has reached the shortlist stage. Interviews are due to be held on 7 June 2006. The remaining five sessions a week of this whole-time post will be linked to St George's London University. The 0.5 WTE devoted to the PICU will ensure that consultant psychiatrist staffing for the unit remains within the relevant Royal College of Psychiatrists guidelines.

- The current ward manager has re-written the Operational Policy for John Meyer Ward and it provides a sound operational framework for the PICU (See also Para. 7.6. below).

- The staff the review team spoke to were generally appreciative of the combination of clarity through the Operational Policy of what was expected of them and of good person-centred management from the ward manager.

Comment

Psychiatrist provision to the ward appears to have reached an acceptable level, particularly with the appointment of a whole-time senior house officer post, and a substantive consultant psychiatrist responsible for sharing the clinical leadership of John Meyer Ward with the ward manager. More focus now is needed on developing multi -disciplinary work and accountabilities.

In other respects, the management of the ward now appears to be well structured and operated with a style that combines clarity of expectation with good person-centred management sensitive to the demanding and sometimes stressful nature of work on a PICU.

Recommendation 8

Now the appointment of a substantive consultant psychiatrist to share the clinical leadership of John Meyer Ward with the ward manager has been confirmed. Further development of the ward team should now be undertaken using an appropriate tool, for example the "Creating Capable Teams" tool kit developed by the Sainsbury Centre for Mental Health and the National Institute for Mental Health in England (NIME).

7.3. Developing good practice

It was evident from the internal inquiry report that the PICU was at the time of the incident isolated from other parts of the Adult Services Directorate and from the Trust as a whole. That sense of remoteness and lack of connection between component parts of the organisation had also been referred to in the CHI clinical governance review in early 2003. One of the consequences of such isolation may have been a difficulty in staying in touch with best practice in the Trust and beyond. The review

team wanted to explore whether the emphasis on developing good practice had improved on John Meyer Ward since it re-opened. (Initiatives to improve the quality of practice and services across the Trust as a whole are discussed later in this report.)

- Two of the Trust's consultant nurses have been closely involved in the design and delivery of skills training for John Meyer Ward staff.

- Since the internal inquiry a number of workshops have been provided for staff on John Meyer Ward including health care assistants, covering:

    - Practice development – three day workshop – facilitated by RCN Practice Development Institute.
    - Team working and care planning – four day workshop – led by nurse consultants.
    - Practice development – two day workshop – for deputy ward managers.

- A well-structured induction programme is now in place for all new staff.

- Mandatory training is now taken up and a system in place to monitor attendance and identify when refresher training is due.

- The Trust is a member of the National Association of Psychiatric Intensive Care Units (NAPICU) from which regular updates on best clinical practice can be found. The review team were told that these are discussed at weekly nurse staff meetings and at regular meetings of the ward's Clinical Care Forum which includes representation from service-users. The forum also provides an opportunity for the ward to move towards creating "shared governance time", an opportunity to reflect on examples of good practice or on incidents or issues arising in practice, from which lessons can be identified, learned and where appropriate shared beyond the ward, for example through the Acute Care Forum.

- Staff who spoke to the review team said clinical supervision and appraisal were patchy. Lack of time on a busy ward was cited as the main reason that regular supervision did not happen. Some staff also said there was no "protected time" set aside on John Meyer Ward. The lack of time for de-briefing after incidents on the ward was also mentioned.

- John Meyer Ward is participating in the Trust's Practice Development Programme, introduced by the Chief Nurse following her appointment two years ago. This links practical work-based development issues with modules for academic recognition. A John Meyer Ward project on the use of seclusion is included in the programme led by a staff nurse with a deputy ward manager and the ward manager as associate project leaders.

- One of the relatively newly qualified staff nurses is undertaking post-graduate work on psycho-social intervention at Kingston University for one day a week, funded by the Trust as part of his personal development but which also benefits practice on the ward.

- Staff and the ward manager participate in the Trust's Good Practice and Expert Seminars and in *ad hoc* events, like the recent series of workshops for staff aimed at learning the lessons from Eshan's death.

- The ward manager attends regular practice development and ward Managers meetings within the new borough structure.

- The Ward participates in surveys of patients' views as part of the Trust's "Changing the Way We Work" programme. (See also Para 7.7 and Section 11 below)

Comment

The recent work of the staff and the ward manager on John Meyer Ward to ensure that the PICU is integrated into the mainstream of the Trust's services and to identify and develop good practice is to be commended.

The implementation of regular clinical supervision and staff appraisal for all staff appears patchy.

It is important that opportunities are taken and that time is allowed to reflect on and monitor change and continued improvement so as to derive maximum benefit from the Practice Development Programme and staff training, particularly post-graduate nurse training.

Recommendation 9

The Trust should ensure that regular clinical supervision is a priority and that staff appraisal for all staff is consistent across all locations and services, regularly monitored and audited.

7.4. Seclusion policy and practice

- We examined the references to seclusion in the current John Meyer Ward Operational Policy (See also Para. 7.6. below) and noted the appropriate and helpful annex to the Operational Policy of the Trust's Seclusion Policy (part of the Policy for Management of Violence and Aggression). This provides a clear description of the purpose of seclusion as a last resort. It deals with the decision to use seclusion and management of a patient in seclusion and specifies procedures for entering and exiting a seclusion room with explicit instructions for the minimum number of staff to be present. The policy goes on to deal with meals, toilet facilities, length of time in seclusion and termination of seclusion. It was evident from the discussions with staff, the ward manager and general manager that the staff on John Meyer Ward are aware of, understand and comply with the seclusion policy.

- A project on seclusion on John Meyer Ward has been accepted into the Trust's Practice Development Programme. (See Para. 7.3. above).

- The Mental Health Act Commission Annual Report 2004/5 had recommended that the Trust "should complete cessation of the use of seclusion as soon as possible and preferably within one year; and should take all necessary strategic and operational steps to achieve this challenging goal". Seclusion is now closely monitored and audited by the Trust, but its use has not ceased. The cessation of seclusion remains a subject of national debate. Seclusion as a last resort where de-escalation techniques, observation, restraint or medication or a combination of these interventions have not succeeded remains a valid option. The indications are that its use on John Meyer Ward has decreased. The safe use of a clear policy for seclusion as implemented in the Trust and on John Meyer Ward remains appropriate as a last resort until a sound evidence-based consensus is available.

7.5. Staffing and Cultural Issues

Concerns were identified in the internal inquiry report about the skill mix of nurses and health care assistants on duty on the night of the incident and regarding the management of staffing rotas. The review team discussed the present position on these issues with staff groups and the ward and the general manager.

- Who managed the staffing rota was unclear until the arrival of the present ward manager. This is now the responsibility of the ward manager and the day-to-day work on the rota is undertaken by a nominated deputy ward manager. The present ward manager worked personally on the rotas for a period after his arrival to ensure that any previous influences were dealt with as a high priority.
- The mix of qualified to unqualified staff on duty on each shift was usually three qualified and three unqualified.

- A typical shift consisted of four permanent and two agency staff; the agency staff normally being individuals who worked regularly on the ward. But occasionally new agency staff are used and need to be inducted by the permanent qualified staff members. The gender balance on shifts was not generally seen as a problem, though one male member of staff said an over-provision of female staff was "anxiety-provoking in an all-male PICU environment".

- The staff on John Meyer Ward are from diverse ethnic backgrounds. This brings a richness of experiences and perspectives. Some examples of racial abuse by patients were described during the meetings. Staff can clearly see this in the context of the patients' mental illness, but the review team would like to have seen evidence of a clear policy in the Trust for promoting equality and diversity for services and staff (See also Para 4.7. above concerning noting any patient history of racially motivated violence and linguistic difficulties).

Comment

The regular use of agency staff, however should be reviewed in respect of continuity and quality of care provided to patients.

Recommendation 10

The nursing skill mix including the use of agency staff for inpatient wards as well as the PICUs should be regularly reviewed in line with evidence-based practice and service developments.

Recommendation 11

The Trust should review as soon as possible its strategy and action plan for equality. (See also Recommendation 14 below).

7.6. The John Meyer Ward Operational Policy

The present ward manager wrote the Operational Policy for John Meyer Ward soon after his appointment. He consulted outside including the Mental Health Act Commission, Nursing and Midwifery Council and NAPICU. The Operational Policy was written from the viewpoint of the staff and in a way that enabled their understanding and endorsement. It was submitted to the Trust's Risk Management Committee for consultation and approval.

We also reviewed the operational policies in place at the time of the incident.

Comment

The current Operational Policy is comprehensive and an improvement on its predecessors. There are, however ways in which it could be improved further, building on the good work to date. There is an opportunity as part of planning for the new purpose-built PICU to refine the Operational Policy. Suggested areas for consideration are included in Appendix D.

Recommendation 12

The opportunity should be taken to refine the John Meyer Ward Operational Policy, building on the good work to date, in preparation for the move to the new purpose-built PICU.

7.7. The patient experience

We were pleased to hear in a number of the fieldwork meetings of work led by the director of quality assurance and user/carer experience and a user consultant to evaluate people's experience of being an inpatient on John Meyer Ward. The review team reviewed the reports of the surveys carried out in August 2005 and March 2006 as part of the Trust's "Changing the Way We Work" programme and discussed them with the director of quality assurance and user/carer experience. The review team also

welcomed the opportunity to meet with a group of the Trust's service users one of whom was a patient on John Meyer Ward several years ago, before the incident.

- The first survey in August 2005 was conducted to provide the John Meyer Ward staff team and managers with information about what it was like to be a patient on the unit. The purposes of the survey were to: "Gain the views of inpatients about the unit and ways in which the care provided could be improved" and "provide a baseline for evaluating the impact of changes made on the experience of being an inpatient on the Unit". Eight of the 10 patients on John Meyer Ward on 3 August 2005 agreed to be interviewed, although one was unable to finish the interview.

- The second survey was in March 2006. Its purpose was to: "Evaluate whether the action plan developed as part of the 'Changing the Way We Work' programme and other concurrent service/practice development initiatives, had a positive impact on the experience of being an inpatient on John Meyer Ward"; and "Provide the staff team with information about ways in which the experience of being an inpatient on John Meyer Ward could be further improved". Five of the nine patients on the Ward on 1 and 2 March 2006 agreed to take part in the survey.

- The surveys were comprehensive. They covered: the overall experience; admission; the physical environment; safety; food and drink; activities; contact with staff; the way staff treat people; provision of information; involvement in decisions about treatment and help; treatment and help received; and visitors.

- The reports of the surveys were helpfully set out to provide a summary of the outcomes in each area covered and then to pose questions arising from those outcomes. For example, in the report of the first survey under the admission process heading the report states: "Although, perhaps unsurprisingly, most people did not wish to be admitted, the majority felt that staff made them welcome". A series of questions was then posed arising from the detail of responses from patients, for example "How can we make sure that people are given enough information and asked about any special needs they may have?"

and "Being admitted to a PICU can be a frightening experience. How can we help people to feel less anxious?"

- The report of the second survey provided comparisons with the outcomes of the first survey. For example, on admissions. The number of people who said they had been shown round the ward doubled from 50% to 100%. On the physical environment however, deterioration in satisfaction with cleanliness was reported. In overall terms there was a discernable and measurable improvement in the level of satisfaction between the two surveys. Both found that patients felt that there was not enough to do on the ward. The second survey found a problem with lack of activities at evenings and weekends.

- An overall Trust-wide report on "The Experience of Adult Inpatient Care" showed few differences between the experience of inpatient care reported by those who defined themselves as being of white or Asian/British Asian origin. However, there were a number of key areas in which those defining themselves as black or black British (Black African, black Caribbean or other black) were markedly less satisfied with their experience of inpatient care than their white or Asian/Asian British counterparts.(See Recommendation 11 and Para 7.4. above and Recommendation 14 below).

Comment

By briefly describing the purpose, process and a few examples of outcomes of these surveys the review team hope to highlight the professional and systematic approach found. It is encouraging that overall levels of satisfaction of service-users appear to be improving. The review team are satisfied that staff on John Meyer Ward is using the outcomes and the questions posed to help them to continue to improve services and the experience of the people receiving them. We were pleased to hear that the programme of evaluating user experience of services extends Trust-wide.

- The meeting with a group of service users was helpful in gaining a non-professional perspective for the review. One of the group of four people the review team met was employed by the Wandsworth Care Alliance Voicing Views Project and had also used mental health services. A service user is now a member of the Trust's Borough Executive (senior management team) for Wandsworth and had been involved in the "Improving the Patient Experience" initiative.

- One of the group was a patient on John Meyer Ward over four years ago and described the experience then as "scary, like a survival test". He acknowledged, however, that there had been improvements since.

- In relation to local mental health services in general the group identified their top priorities as:

    - Community support service – tackling isolation and a joined-up approach to housing.
    - Improving care of patients on wards – developing better therapeutic relationships and activities.
    - Good customer care services – respect.

Recommendation 13

The John Meyer Ward team should continue efforts to improve services in light of the patient experience survey findings. Particular emphasis is needed to find ways of improving the range of activities for patients, particularly at evenings and weekends.

Recommendation 14

Building on the evidence from the work on "The Experience of Adult Inpatient Care", the Trust should explore further the reasons for the variances in levels of satisfaction with the service between people defining themselves as black or black

British and their white or Asian / Asian British counterparts. The outcomes of this further work could help to address the reasons for dissatisfaction and inform the Trust's Equality Strategy. (See also Recommendation 11 above)

8. Governance and the Trust's policy framework

Our terms of reference required the review team to check that lessons had been learned and improvements made after the incident and the internal inquiry. Many of the relevant issues are covered in Sections 4 and 5 of this report. This section examines the framework for governance in the Trust and comments upon the policy framework within which the Trust's services provided. The review team looked at a number of the Trust's key policies (See Appendix B) and discussed the governance framework including clinical governance with a wide range of directors, managers and staff.

8.1. Governance

- The CHI clinical governance review in late 2002 is discussed in para 6.1. above. There have since been a number of important changes in the Trust's governance arrangements. The Trust Board approved the present Trust Governance Framework on 28 July 2005. It takes into account changes to the management structure, Department of Health recommendations regarding Integrated Governance Framework (April 2005) and subsequent Handbook (February 2006). Also the requirements of the (then) new NHS planning and performance framework, incorporating national core and developmental standards.

- An Audit Committee now reports direct to the Trust Board. This is in effect an integrated governance committee. The review team found that the name of the committee caused some confusion. Audit was regarded by some people the review team met as a narrow or financial process. In practice the Audit Committee deals with a wide range of matters relating to, for example, corporate and clinical governance including risk management (clinical and corporate), incident reviews, information governance and equality. It might be better to give consideration to renaming this committee so clearer clarification and understanding is given to its range and purpose.

- A number of sub-committees of the Trust Executive are placed within the structure. There is, however, no group identified to look specifically at clinical governance across the Trust or to advice on clinical excellence. No prescribed structure for clinical governance was proposed for the borough and Support Services within the Trust. However, it was clear from the discussions that the Wandsworth Boroughs Directorate is developing a clear approach to governance with cross-representation to the Trust-wide elements of the governance arrangements. (See below).

Comment

The Trust's Governance Framework now appears to be robust and fit for purpose. It would, however, benefit from the addition of a Trust-wide clinical governance or clinical excellence group. The review team were pleased to hear that proposals for such a group were being developed. Action is needed to ensure that consistent clinical supervision and staff appraisal practice is in place across the whole Trust. (See Para.11.4. and recommendations 9 and 24).

- We were told that each borough now has a governance group. Each borough was in the process of setting up "Service Improvement Groups"; smaller groups of frontline staff and managers. The Trust's Governance Department, led by the assistant director governance, will focus on supporting those frontline groups.

- Our meeting with the Borough Executive Wandsworth confirmed that a borough governance group had been established attended by all general managers in the borough and with clinical representation.

- In discussing the interface between the Trust (corporate) and the boroughs some concern was expressed about the "distance between the two levels". It was clear that good and regular links were maintained between the borough directors (individually and as a group) and the Chief Operating Officer, but it was suggested that there was scope to engage borough directors more in the development of the Trust's direction and strategy.

- We were pleased to hear from a number of sources that arrangements for monitoring and reviewing critical incidents had improved, particularly over the past year. Formal reports go the Trust's Performance Group (part of the Governance structure). In addition monthly meetings of the Safety Working Group chaired by the Chief Nurse are held to specifically monitor and address critical incidents. Membership of this group includes the Medical Director and Borough Service Directors. This is in addition to the formal quarterly reports on Serious Untoward Incidents to the Trust Board.

- Tracking of incidents was assisted through Ulysses Safeguard software. (But see also Para 5.1. and recommendation 2 above regarding the format of action plans and development of appropriate monitoring tools). A training programme is underway for ward managers concerning the grading of low-level incidents with follow-up by the Trust's risk managers to check for consistency and identify trends.

- Clinical audit is only one part of the governance process, but it is important in checking on compliance with key Trust policies, for example record-keeping, CPA and risk assessment. The review team were concerned to hear that at the time of the fieldwork three vacancies existed in a relatively (for a Trust of this size) small team of four posts in the clinical audit team.

Recommendation 15

The Trust should consider urgently the resources devoted to and structure of the clinical audit team to offer career progression and to improve retention of staff.

8.2. The Policy Framework

We examined a wide range of clinical and non-clinical policy documents. (See Appendix B).

- Many of the policies were relatively recently updated and most included on the front cover a date of implementation and a date for review, but the review team did not see evidence of a systematic approach to ensuring that all policies were reviewed on the due date. Some policies appeared to be overdue for review, for example the Critical incident Policy and Procedure and the Illicit Substances and Alcohol Misuse Policy. The review team were not sure that an appropriate process was in place to ensure that all services, wards and teams maintained a readily accessible up-to-date portfolio of all the Trust's policies and procedures.

- The internal inquiry recommended that the Trust should review its methods of cataloguing policies and procedures and ensure a common format for issuing and reviewing policies. The January 2006 update to the action plan suggests that this recommendation, which the review team endorse, is not yet fully implemented.

Recommendation 16

The Trust should examine all its policies and procedures to ensure that they are up to date, and establish a process for monitoring and the regular auditing of their implementation. Where reviews of policies and procedures are overdue or necessary they should be completed as soon as possible. A system should be put in place to ensure that a regularly updated portfolio of Trust policies and procedures is readily accessible for all services, wards and teams. Consideration should be given to a standardised format for all policies and procedures whether Trust-wide or local with a front sheet providing information on the policy number, author, date of publication and review date.

9. The Care Programme Approach (CPA)

CPA was introduced into mental health services in England and Wales in 1991. A Department of Health Policy booklet "Modernising the Care Programme Approach" 1999 confirmed CPA as *the* framework for care coordination in mental health care. When patients meet the eligibility criteria, CPA is applicable throughout their mental health care and treatment. The review team wanted therefore to explore the extent to which CPA is embedded as *the* way of working on John Meyer Ward.

- The responses the review team received during the field work meetings were inconsistent concerning the extent to which CPA is applied on John Meyer Ward. Some staff told the review team that there were no CPA meetings on John Meyer Ward but that care co-ordinators from CMHTs came in occasionally for ward rounds and staff from John Meyer Ward have been invited to and have attended CPA meetings elsewhere.

- Some people said there was a lack of involvement from CPA care coordinators and related this to workloads in CMHTs and with the management of the mix of caseloads in CMHTs. (The scope and timescale for the review did not permit the review team to pursue this matter, but see comments below).

- We were told the PICU did not have much involvement with discharge planning / CPA because patients were almost always transferred back to an acute ward and rarely discharged (to the CMHT). The PICU would be involved, on the rare occasions when patients were discharged directly to the community.

- Senior clinicians and senior managers told the review team of concerns about the lack of consistency in the use of CPA across the Trust. The associate medical director Wandsworth is leading a review of the Trust's CPA Policy via the Acute Care Forum. Some doubts were expressed to the review team about whether CPA was *the* way of working in the Trust.

- CPA information is now available to John Meyer Ward staff through the new electronic CPA system (eCPA) as "read only". This is useful in providing information on patients when admitted, for example on risk and offending history. Such information was not available electronically at the time of the incident in 2003. The review team were assured that this does not obviate the need to carry out a risk assessment on admission to the PICU.

- Some nursing staff on John Meyer Ward were now trained in the use of eCPA.

- We heard evidence of CPA audits being carried out as part of the annual audit of record-keeping. Audit of risk assessments was undertaken as part of CPA audits. The review team were concerned about capacity within the Trust to audit systematically the practice of and compliance with CPA given the present vacancies in the audit team. (See Para. 8.1. and recommendation 11 above).

- Risk assessment is an integral part of the CPA process.

The Mental Health Act Commission Annual Report on the Trust (2004/5) expressed dissatisfaction with the relative lack of CPA procedures being applied to inpatients, detained under the Mental Health Act across the Trust not specifically on John Meyer Ward. This resulted, according to the commissioners, in inadequate planning of continuing care and support for patients, who said lack of clear plans for their care was unsettling.

Comment

It appears that the Care Programme Approach is not yet consistently embedded in the Trust as <u>the</u> way of working. The problem identified by the Mental Health Act Commission of CPA not spanning the care pathways of patients, for example for periods in which they may be admitted to hospital or transferred for care and treatment in a PICU, appears to persist.

The apparent inconsistency in and lack of engagement of CPA care coordinators in such an important stage of the patients' care pathway as admission to a PICU is

of concern and needs to be addressed. More work is needed on John Meyer Ward to ensure that the care and treatment of patients, relates to and influences their individual CPA care plans.

Recommendation 17

In addition to the current review of the Trust's CPA Policy, a review of CPA practice in the Trust should be undertaken and completed as a high priority to: identify areas for further improvement and consistency; develop an action plan; make improvements and ensure implementation is monitored. Particular attention should be paid to the seamless continuation of CPA and engagement of care coordinators when patients are admitted to hospital or transferred between inpatient wards.

Recommendation 18

The Trust should consider appointing a trust-wide CPA coordinator to continue the drive to improve CPA practice and compliance across the trust. This officer should be of suitable seniority.

10. Risk management and risk assessment

The management and assessment of risk were key issues in the period leading to the events of 16/17 July 2003. This review sought to identify how the risk management framework and the practice of managing and assessing risk had changed since. The review of policies and procedures included the Trust's Clinical Policy on the Care Programme Approach, Care Management and Risk Assessment and Care Management - dated February 2001 and marked as due for review in March 2003. The review team also reviewed the Risk Assessment Policy and Guidance -dated January 2004 and marked as due for review in January 2006. (See also para. 8.2. and recommendation 16 above regarding updating and review of policies).

The 2001 CPA Policy makes clear that all patients subject to enhanced CPA must have a risk history form completed and where there is no known risk history this must be recorded on the form. A "Relapse and Risk Management Plan" must be drawn up where there is a significant risk.

- The internal inquiry found that ward policies and procedures were generally weak at the time of the incident. That concern could also have applied to the lack of coverage of risk management and risk assessment matters in the Operational Policies applicable to John Meyer Ward at that time. The internal inquiry also recommended the review of a range of Trust-wide policies. It appears that most of those reviews are underway (according to the January 2006 action plan update) but it is of concern that few are yet completed. (See also para. 8.2. and recommendation 16 above).

- The current John Meyer Ward Operational Policy emphasises that the provision of care is underpinned by principles of risk assessment and management. Assessment of risk is also highlighted within the care pathway procedures in the Operational Policy. Specific reference is made to risk assessments with regard to access to the garden. Appendices to the Operational Policy deal with (among others) security, management of violence and aggression including anticipation of violence, rapid tranquilisation and seclusion, abscondence, visitors, search

policy, lone working and the roles of the Security Nurse and the Health and Safety Coordinator.

- Discussions with ward staff and the ward manager confirmed that assessment, awareness and management of risk now permeate the everyday work of John Meyer Ward. This includes a consideration for each patient at each shift handover of patient behaviour, whether any risks are identified, readiness for transfer, any review of medication and warning signals (including "hunches" of staff). Risk assessments are also updated at daily meetings. The rule of thumb about risks whether clinical or non-clinical is: "If in doubt call upon the (Trust's) risk management team for an assessment, including for health and safety advice". The staff emphasised (as had the internal inquiry) the vital importance of good induction for staff new to the PICU. They felt that the induction programme was now comprehensive and fit for purpose. Two of the HCA's the review team met had been in post on John Meyer Ward for 14 and over six years respectively. Their view was that it is not easy to be a HCA on a PICU but it now feels safer with more attention to risk and management, both clinical and in the security and safety of the environment.

- Zoning is an applied clinical risk management strategy which helps to prevent hospital admissions and ensures that patients receive the right support. It involves daily review and allocation of each patient to a zone (red, amber or green) to plan appropriate care and support. The review team have not yet seen evidence-based evaluation for this applied strategy, but the enquiries suggest that it is becoming more widely used. It appears to be an effective tool in identifying and managing service-users with high-risk behaviour. It appears therefore to be transferable to PICUs.

- A number of people the review team spoke to talked about the introduction across the Trust as a whole of "zoning". It was introduced to the Trust by the Chief Operating Officer who had seen it successfully implemented across another similar-sized Trust. One of the nurse consultants is taking the lead in implementing it in the South West London and St George's Trust. Zoning is also

being introduced in the Pennine Care NHS Trust and South London and the Maudsley NHS Trust.

- In the South West London and St George's Trust zoning is being piloted in Crocus Ward an Adult Acute Mental Health Admission Ward and in West Battersea Community Mental Health Team. It will then be implemented in Jupiter Ward and Wards in the Sutton Borough Directorate. The intention is to implement zoning on John Meyer Ward. It is expected to bring potential advantages of a clear structured process and a capacity to help plan in detail for the working day, including the allocation of staff resources for shifts. It is also accepted that care will be needed in implementing it within PICUs to ensure that risks within each of the zones are recognised and addressed.

Comment

We have not seen evidence-based evaluation of zoning, but it appears from pilots in the Trust and in two other Mental Health Trusts in England to have real possibilities to: provide consistency in the use of a core risk-assessment tool across the Trust; data to help plan future services; information to help with caseload and workload management in CMHTs; daily information to enable clear and detailed planning of the day on inpatient wards; and dialogue with commissioners.

Recommendation 19

The Trust should continue to introduce and evaluate zoning pilots for risk-assessment with a view to expanding zoning across the Trust.

Recommendation 20

Work should be commissioned to *embed* zoning into the Trust's CPA policy and procedures.

Recommendation 21

Implementation of zoning on John Meyer Ward and elsewhere should develop as a team process. It should be developed on John Meyer Ward as an action research project and be subjected to evaluation, perhaps as part of the Trust's Practice Development Programme.

11. Organisational staff and personal development

The internal inquiry report identified concerns about the organisational structure and framework of the Trust at the time of the incident. It concluded that there was a need for the Trust-wide development of professional leadership and of nursing practice. It also highlighted the need for strong systems for performance management and personal development of staff.

This section deals with each of these components of the organisational development of the Trust and assesses the progress since the incident and the subsequent completion of the internal inquiry.

11.1. Organisational structure and framework

- The final paragraph of the conclusions section of the internal inquiry report said: "There is a dislocation between the clinical management structures and the (Trust) Executive Team leading to an absence of sound performance management systems that link across clinical and general management". The Trust's structure at that time had been within nine Directorates, each with a service manager and a clinical director. The clinical director had in effect overall management responsibility for the Directorate. The role of service managers was limited to the management and supervision of non-medical staff. There was no over-arching general management function in the Directorates or corporately for the Trust as a whole. This was unusual for a Mental Health Trust in the late 1990's/early 2000's. It was also unusual for a Mental HealthTrust of this size not to have a strong "locality" element to its structure and operations.

- An earlier conclusion in the internal inquiry report indicated that the Trust's management structure at the time of the incident might benefit from review in light of the emerging health and social care agenda and the size and complexity of the organisation. The conclusion continued: "There is a need to consider the current management arrangements with a view to strengthening the teamwork in the overall performance management of clinical services within the Trust."

- The earlier CHI clinical governance review in late 2002 fell short of suggesting wholesale management re-structuring but said: "The Trust needs to review corporate and clinical directorate portfolios, particularly where there is an excessive workload for clinicians in management."

- The response of the Trust has been radically to change its management structure following a period of wide consultation with mangers, clinicians, staff and partner organisations.

- The new structure is described in the Trust's Annual Report 2004-2005. It includes a chief operating officer reporting directly to the chief executive and five borough service directors reporting to the chief operating officer. The structure is therefore now locality-based, recognising the borough boundaries within which services are delivered to local populations. Each borough Directorate has an executive (senior management team) which includes an associate medical director, an associate director of nursing and general managers. The potential advantages of the new structure are described in the Annual Report. The implementation of the new structure started with the appointment of the chief operating officer, followed in the summer of 2005 by the borough director appointments.

Comment

The new structure both strengthens the general management function and devolves management of local services. The new arrangements are still taking effect, but the meetings with directors, managers, staff and service users suggest that the early signs of improvement, for example in closer links between the operational and corporate functions in the Trust, are encouraging. However devolved, locality-based service management needs the support of a strong, clear corporate framework. Work has begun to achieve this, but it is in it's early stages.

Recommendation 22

The Trust should ensure that the corporate framework within which devolved management and clinical leadership can thrive is developed to allow for local variations to meet local needs but within agreed parameters. (See also paras. 11.2 to 11.5 below). There should be a clear plan for this development which can be monitored.

11.2. Vision, priorities and business planning

- The Trust's aims and goals are set out in the Annual Report 2004/5 and on the Trust's website. The Trust Executive has recently re-evaluated priorities. Drawn from the Trust's existing Service improvement plan, which identifies 365 recommendations from internal and external inquiries and from visits and reports from outside organisations, a number of recurring themes have been recognised. The Trust has therefore decided to include in its Business Plan for 2006/7 a Service Improvement Plan built around an identified top 10 areas for the improvement of clinical services. The themes are:

    - Clinical and managerial leadership
    - Ward/Team development
    - Record-keeping
    - Supervision and appraisal
    - Ownership of policies and procedures
    - Recruitment
    - Codes of conduct and culture
    - Risk-assessment and risk-management
    - Therapeutic activities
    - Facilities improvement

- We were told the Trust has no history of business planning. The focus had concentrated on service and management re-organisation during 2004/06. Since then a business plan has been developed for 2006/07. The business plan aims to articulate and drive the implementation of the overall vision and direction of the trust with the Service Implementation Plan being an integral part.

Comment

Developing a consistent process of business planning across the Trust will be an important component of the corporate framework. It will require a clear view of priorities developed in dialogue with staff, operational managers, service-users and carers and partner organisations. The business planning process is the way in which the Trust can allocate resources and timescales to ensure that key priorities for the year ahead are achieved.

The 10 themes appear to be a good starting point for the process of identifying and refining priorities. The review team would have included CPA as a theme in its own right. (It is included as a sub-theme under Record-keeping).

Recommendation 23

The Trust should continue its work developing and implementing its business-planning process.

11.3. The nursing strategy

- The Trust approved its Strategy for the Development of Nursing on 19 April 2006. It is an important component of the overall corporate business plan. It outlines the expectations of nursing, considers the role of the Nursing Directorate and provides detailed plans for 2006 to 2008. The six core strands to the strategy are:

- Enhancing the patient and carer experience
- Education training and practice development
- Leadership
- Improving working lives
- Research
- Information technology

- Actions, process and outcomes are described and target dates are set for each strand.

- All the elements of this detailed and comprehensive strategy are of relevance to the issues about the quality of nursing practice and the relative status in the Trust of nursing as a profession - as highlighted by the internal inquiry following the tragedy on John Meyer Ward. In particular the Education Training and Development part of the strategy deals with appraisal and the introduction of a supervision monitoring tool. It also, for example, specifies a modular NVQ approach for training HCAs and a 'leadership at the point of care' course aimed at HCAs and Band 5 nurses.

- We were pleased to hear of a recent initiative within the Wandsworth Borough Directorate to put in place as part of a "Nursing Review Group" development, a core of 10 nurses of all grades and including HCA participation. They are accredited to teach in situ on the wards. One example of such practical ward-based team learning has been risk-assessment. This approach seems commendable because it engages practising nurses in sharing their skills and expertise. It can be seen both as a supplement to the more formal modular approach to education and training. It is also an effective way of ensuring that staff, particularly unqualified staff for which modular NVQ training is difficult, are involved with their workplace colleagues in continuous learning.

Comment

The evidence the review team has seen of recent initiatives to provide a range of structured opportunities for the development of nursing practice in the Trust is

commendable. The challenge now is to ensure that the framework delivers the intended improvements.

11.4. Clinical supervision and staff appraisal

- Supervision is an essential component of good clinical governance. Staff appraisal is equally important as a key element of and a vehicle for organisational development. Both are building blocks of a sound corporate framework. Both are central to the relationship of the individual clinician or member of staff, to the overall aims and objectives of the organisation, to the way individuals can influence the organisation and to how the organisation can secure the support of individuals in achieving its objectives.

- Our fieldwork meetings confirmed consistently that both clinical supervision and staff appraisal operate at best patchily across the Trust.

- We heard that the Trust's Appraisal and Performance Development system, launched some six years ago, was glossy but unwieldy and neither realistic nor grounded. The percentage of staff receiving regular appraisal was said to be low. Work is underway to address the training needs of appraisers within the Borough structures through the Knowledge Skills Framework. It is difficult to see how personal development plans for staff can be consistently developed and implemented without a robust and effective appraisal system. Such a system would allow identified needs of staff to influence the content of the education and training programmes. (See also para. 7.3. and recommendation 9 above).

- A similar picture emerged concerning clinical supervision. This is of concern because the opportunity exists within well-structured clinical supervision to reflect on practice, an important building block of effective clinical governance. (See also Para. 7.3. and Recommendation 9 above).

Recommendation 24

The Trust should review the capacity of its Human Resources (HR) function to ensure that front-line managers and supervisors have adequate support to give effective appraisal and clinical supervision for staff. Staff also will need 'protected time' then to be able to participate effectively in both the appraisal and clinical supervision process. A wider-ranging review of HR capacity to achieve strategic and business plan objectives, including contribution to organisational development and cultural change, is also needed.

11.5. Organisational development

- Throughout this report the review team have reviewed and commented upon a number of building blocks for and initiatives towards the organisational development of the Trust. They include:

  - New borough-based management structure with strengthened nursing, medical and general management leadership.
  - Practice development programme.
  - Good-practice seminars.
  - Expert seminars.
  - 'Changing the Way We Work' programme.
  - Specific development and leadership programmes for John Meyer Ward staff with expert external and internal support and facilitation.
  - The governance framework and service improvement groups.
  - Strategy for the development of nursing practice.
  - Nursing Review Group – Wandsworth.
  - Role of consultant nurses.
  - Trust Development Forum - for top and level 2 managers across the Trust.
  - Human Resources strategy.
  - Business-planning process.
  - Service Improvement Plan and the top 10 themes.

- However, many of these initiatives are at an early stage and the review team have not seen a clear framework for organisational development in the Trust.

Recommendation 25

The Trust should produce a cohesive organisational development plan to clarify and share its vision for the development of the organisation, building on initiatives already underway. An Executive Director of the Trust should be given responsibility to do this.

12. Summary of recommendations

1. **The Trust should consider the gaps and issues for debate in the internal inquiry report identified in this review to establish whether they have been addressed since the internal inquiry and, where they have not, ensure that appropriate action is taken. (Page 27)**

2. **The Trust should consider adding a column to its format for Action Plans to record evidence of completed actions. Further improvements are needed to the format to ensure that Action Plans are effective monitoring tools to enable the recording and continuous review of actions until they are signed off, with evidence of completion recorded. (Page 28)**

3. **The Trust should review its arrangements for managing health and safety systems and consider appointing a Health and Safety manager to strengthen its overall structure for risk management. (Page 34)**

4. **The Trust should review its arrangements for managing security, including designating a local security management specialist (LSMS). (Page 37)**

5. **It is essential that the re-provision of the PICU on the Springfield Hospital site is commissioned and completed as soon as possible. (Page 39)**

6. **The Trust should audit and review response times from its Estates Department to requests for repairs in areas where patients may be at high risk. (Page 39)**

7. **Pending the completion of the new purpose-built PICU, the Trust should consider further short-term improvements to the existing ward, for example through the use of colours, light and space. (The King's Fund "Enhancing the Healing Environment" programme and the NHS Estates "Art of Good Health" series offer some useful advice). (Page 39)**

8. **Now the appointment of a substantive consultant psychiatrist to share the clinical leadership of John Meyer Ward with the ward manager has been confirmed. Further development of the ward team should now be undertaken using an appropriate tool, for example the "Creating Capable Teams" toolkit developed by the Sainsbury Centre for Mental Health and the National Institute for Mental Health in England (NIME). (Page 41)**

9. **The Trust should ensure as a high priority that regular clinical supervision and appraisal for all staff is consistent across all locations and services and that it is regularly monitored and audited. (Page 44)**

10. **The nursing skill-mix on inpatient wards including the PICUs should be regularly reviewed in line with evidence-based practice and service developments. (Page 46)**

11. **The Trust should review as soon as possible its strategy and Action Plan for equality. (Page 46) (See also Recommendation 14 below)**

12. **The Trust should take the opportunity to refine the John Meyer Ward Operational Policy, building on the good work to date, in preparation for the move to the new purpose-built PICU. (Page 47)**

13. **The John Meyer Ward team should continue efforts to improve services in the light of the patient experience survey findings. Particular emphasis is needed to find ways of improving the range of activities for patients, particularly at evenings and weekends. (Page 50)**

14. **The Trust should build on evidence from "The Experience of Adult Inpatient Care" to explore further the reasons for the variances in levels of satisfaction with the service between people defining themselves as black or black British and their white or Asian/Asian British counterparts. The outcomes of this further work could help to address the reasons for dissatisfaction and inform the Trust's Equality Strategy. (Page 50) (See also Recommendation 11 above)**

15. **The Trust should consider urgently the resources devoted to and structure of the Clinical Audit Team to offer career progression and to improve retention of staff. (Page 54)**

16. **The Trust should examine all policies and procedures to ensure that they are up to date. Reviews of policies and procedures that are overdue or necessary should be completed as soon as possible. A system should be put in place to ensure that an up-to-date portfolio of the Trust's policies and procedures is readily accessible for all services, wards and teams and that it is regularly updated. Consideration should be given to a standardised format for all policies and procedures whether Trust wide or local with a standardised front sheet providing information on policy number, author, date of publication and review date. (Page 55)**

17. **In addition to the current review of the Trust's CPA Policy, a review of CPA practice in the Trust should be undertaken and completed as a high priority to: identify areas for further improvement and consistency; develop an action plan; deliver improvements and ensure that a robust process is in place to monitor implementation. Particular attention should be paid to the seamless continuation of CPA and engagement of care coordinators, when patients are admitted to hospital or transferred between inpatient wards. (Page 58)**

18. **The Trust should consider appointing a trust-wide C.P.A. coordinator to continue the drive to improve C.P.A practice and compliance across the trust. This officer should be of suitable seniority. (Page 58)**

19. **The Trust should continue to roll out and evaluate the zoning pilots for risk assessment with a view to expanding the use of zoning across the Trust as a whole. (Page 61)**

20. **Work should be commissioned to realise the opportunity to embed zoning into the Trust's CPA policy and procedures. (Page 61)**

21. **Implementation of zoning on John Meyer Ward and elsewhere should be developed as a team process. It should be developed on John Meyer Ward as an action research project and be evaluated perhaps as part of the Trust's Practice Development programme. (Page 62)**

22. **The Trust should ensure that the corporate framework within which devolved management and clinical leadership can thrive is developed to allow for local variations to meet local needs but within agreed parameters. (Page 65)**

23. **The Trust should continue its work developing and implementing its business-planning process. (Page 66)**

24. **The Trust should review the capacity of its Human Resources (HR) function to ensure that adequate support is provided for front-line managers and supervisors to deliver effective appraisal and clinical supervision for staff. Staff also will need 'protected time' then to be able to participate effectively in both the appraisal in clinical supervision process. A wider-ranging review of HR capacity to achieve its strategic aims and business plan objectives, including contributing to organisational development and cultural change is also needed. (Page 69)**

25. **The Trust should produce a cohesive organisational development plan to clarify and share its vision for developing the organisation, building on the range of initiatives already underway. An executive director of the Trust should be given responsibility for this. (Page 70)**

Appendix A

South West London NHS
Strategic Health Authority

External review of John Meyer Ward following the death of Eshan Chattun

Commissioner

This external review is being commissioned by South West London Strategic Health Authority, with the full cooperation of the South West London & St. George's Mental Health Trust, as part of its responsibilities for performance managing the NHS locally. It is commissioned in accordance with guidance published by the Department of Health in circular HSG (94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community.*

Terms of reference

The review will consider what practical changes have occurred on John Meyer Ward as a result of various investigations into the circumstances of Eshan Chattun's death at the hands of Jason Cann. These earlier investigations include: the South West London & St. George's Trust internal investigation, the Health & Safety investigation following the death of Mr Chattun along with any other HSE reports, a CHI clinical governance review, reports of Mental Health Act Commission visits and other relevant information.

The aim of the review is to provide independent assurance that the recommendations of the various investigations are being implemented and, where necessary, to provide further advice to the trust and strategic health authority about implementation.

The review will:

- Identify the principal themes and recommendations emerging from the various reports.

- Establish what progress has been made implementing the recommendations and why.

- Identify any recommendations that have not been implemented - either in part or in full – and suggest a course of action to the trust and SHA.

- More generally check that lessons have been learnt and improvements have been made and see whether, where appropriate, these have been promulgated more widely in the trust and health community.

- Provide a written report with recommendations to the strategic health authority and the trust.

- Facilitate a workshop at conclusion of the work, to discuss and disseminate the lessons learnt from the review.

Approach

The review will not re-investigate matters looked into by earlier investigations. However, should a serious cause for concern be identified by the reviewers, this should be notified to the SHA and the trust immediately.

The review will be undertaken in two phases.

Phase One

This will be an information and fact-finding phase incorporating the gathering and review of relevant pieces of information to establish the scope of the second phase of the review.

Phase Two

This will include interviews with key staff and managers – either individually or in groups - and may include observations of practice to establish what has changed as a result of the incident. Fieldwork will be carried out on site in the trust.

Publication

The outcome of the review will be made public. South West London Strategic Health Authority will determine the nature and form of publication. The decision on publication will take into account the view of the chair of the review panel, relatives and other interested parties.

Review team

The review team will comprise two members, assisted as necessary by expert advisers with nursing, medical or other relevant experience, and be expected to work promptly and effectively, with the full process completed within 6 months.

The review team will submit regular progress reports to the commissioners.

Dr Anne Mackie
Director of Public Health
South West London Strategic Health Authority
December 2005

Appendix B

Bibliography and list of documents examined

Internal Inquiry

Report of the internal inquiry into the Death of Mamade Eshan Chattun on 17 June 2003 -Jan 2005	South West London and St George's Mental Health NHS Trust (SWLSGT)
Services Improvement Action Plan JC Update Report -Jan 2006	SWLSGT
Critical Incident Status Report -Feb 2006	SWLSGT

Policies and Procedures

Policy on the Care Programme Approach, Care Management and Risk Assessment and Risk Management -Feb 2001- & Draft Review Oct 2005	SWLSGT
Administration of Antipsychotic Long Acting Injections -Trust Wide Medication Policy -Oct 2000	SWLSGT
The Prevention and Therapeutic Management Of Aggression and Violence -June 2000 -Reviewed Aug 2005	SWLSGT
Seclusion Policy -Trust Wide Clinical Policy -Aug 2002 -Reviewed July 2004	SWLSGT

Time Out -Trust Wide Clinical Policy -Nov 2005	SWLSGT
Medical Emergency and Resuscitation -Trust Wide Clinical Policy -Apr 2004	SWLSGT
Policy and Guidance for Lone Working -Trust Wide Clinical Policy -March 2004	SWLSGT
Transfer of Patients -Trust Wide Clinical Policy -Oct 2005	SWLSGT
Policy on Induction for New Staff -Jul 2005	SWLSGT
Psychiatric Intensive Care Units Operational Policy - Trust Wide Clinical Policy -Sep 2002	SWLSGT
John Meyer Ward - PICU- Operational Policy - Sep 2005	SWLSGT
The Commissioning Development, Ratification and Renewal of Clinical; Policies - Trust Wide Clinical Policy - Jun2004	SWLSGT
Critical Incident Policy and Procedure -Oct2004	SWLSGT

Guidance for Managers on Procedures for Dealing with Critical Incident Reporting - Trust Wide Clinical Policy -Nov 2005	SWLSGT
Illicit Substances and Alcohol Misuse Policy -Trust Wide Clinical Policy -Feb 2002	SWLSGT
Nursing Strategy 2006 -2008	SWLSGT

Induction, Training and Education

Induction Pack for John Meyer Ward -Current	SWLSGT
Mandatory Training Course List -Current	SWLSGT
Adult Directorate - Training and Development an Overview -2004/5	SWLSGT
Guidelines for Completion of Training Needs Analysis -2004/5	SWLSGT
Training Needs for PICU Staff -undated	SWLSGT
Appraisal and Performance Development -undated	SWLSGT

Good Practice Seminars – Programmes -Learning from Critical Incidents - 2005/2006	SWLSGT

Service Users and Carers

Putting Users at the Heart of Services - A Framework for Involving People With Mental Health Problems and their Relatives Friends and Carers - Sep2005	SWLSGT
The Experience of Being an Inpatient On John Meyer Intensive Care Unit -Survey conducted Aug 2004	SWLSGT
The Experience of Adult Inpatient Care at South West London and St George's Mental Health NHS Trust - Jan 2006	SWLSGT
The Experience of Being an Inpatient on Wards For Older People -Dec2005	SWLSGT
The Experience of Being an Inpatient On John Meyer Psychiatric Intensive Care Ward - Survey conducted Mar 2006	SWLSGT
Improving and Evaluating User Experience of Service -update Jan 2006	SWLSGT
Count Me In: Results of the 2005 National	SWLSGT

Census of Inpatients in Mental Health Hospitals and Facilities in England and Wales - Implications for the Trust and Actions Taken -Jan 2006	

Replacement of John Meyer Ward

Outline Business Case for the Replacement Of John Meyer and Adult Acute Admission Wards -June 2005	SWLSGT

Other Trust Documents

Current Trust Management Structure -Current	SWLSGT
Proposed Changes to Clinical Services Management Structure -Feb, Jun and Nov 2005	SWLSGT
Trust Governance Framework -Jul 2005	SWLSGT
Proposed Top 10 High Impact Areas For 10 Point Clinical Services Improvement Plan - Mar 2006	SWLSGT
Annual Report 2003-4	SWLSGT
Annual Report 2004-5	SWLSGT
Human Resources Strategy 2006-8	SWLSTG

Human Resources Department Business Plan 2006-7	SWLSGT
"Risky Business" - Newsletters of the Risk Management Team	SWLSGT
Wandsworth Clinical Governance and Training Structure -Current	SWLSGT

Reports and publications from outside bodies

Commission for Health Improvement (CHI) Clinical Governance Review -Feb 2003	CHI
Health and Safety Executive Investigation Report - Fatal Incident Mamade Eshan Chattun 17 June 2003	Health and Safety Executive
Mental Health Act Commission Annual Report - South West London and St George's Mental Health Trust -Oct 2004 -Oct 2005	Mental Health Act Commission
"Voicing Views" - Project for Mental Health Service Users Newsletter -Jan 2006	Voicing Views Project Wandsworth Care Alliance
Effective Care Coordination in Mental Health Service - Modernising The Care Programme Approach - A Policy Booklet	NHS Executive & SSI

From Values to Action: CNO Review of Mental Health Nursing -Apr 2006	Department of Health
Pennine Care NHS Trust Clinical Governance Annual Report -2004-2005	Pennine Care NHS Trust
South London and Maudsley NHS Trust Annual Report -2004-2005	South London and Maudsley NHS Trust
Standards for Better Health	Department of Health
Local Security Management Specialist Role Objectives and Person Specification	CFSMS
Creating Capable Teams Toolkit -2005	Sainsbury Centre for Mental Health & NIME
National Minimum Standards for General Adult Services - PICUs and Low Security Environments -2002	NIMHE
Wandsworth CMHT Review Proposal -Jan 2006	Sainsbury Centre for Mental Health
Enhancing the Healing Environment -2000 and Press Release 2005	Kings Fund

Defining a Good Mental Health Service -A Discussion Paper -Nov 2005	Sainsbury Centre for Mental Health
The Art of Good Health Series -2002	NHS Estates

Appendix C

Individuals and groups who met the review team

Anne Brocklesby	}	
Devan Deeran	}	
Joyce Hansford	}	Wandsworth Care Alliance
Sue O'Connell	}	Voicing Views Project
Paul Stafford	}	
Trust Executive Team		South West London and St George's Mental Health NHS Trust (SWLSGT)
Wandsworth Borough Executive Team		SWLSGT
Alex Onyenaobiya		Ward Manager John Meyer Ward
Raj Rutah		General Manager Adult Services Wandsworth
Chris Hart		Consultant Nurse SWLSGT
Professor Mary Chambers		Chief Nurse SWLSGT

John Meyer Ward Staff
(3x groups of staff including 1 group of health care assistants)

Christine Carter	Interim Chief Executive SWLSGT

Kim Goddard	Assistant Director Governance
Justin O'Brien	Head of Risk Management SWLSGT
Stuart Thomson	Service Director Wandsworth SWLSGT
Maresa Ness	Chief Operating Officer SWLSGT
Sandy Gillett	Director of Human Resources SWLSGT
Karen Oliver	Deputy Director of Human Resources
Dr Deji Oyebode	Medical Director SWLSGT
Dr Mark Potter	Associate Medical Director Wandsworth
Jo Smyth	Risk Manager SWLSGT
Catherine Gamble	Consultant Nurse SWLSGT
Chas Young	Facilities Manager SWLSGT
Margaret Pretty	Principal Inspector Health & Safety Executive (HSE)
Hazel McCullum	Inspector HSE
Kerry Williams	Inspector HSE
Rick Tucker	Head of Security Management Mental Health and Learning Disabilities NHS Counter Fraud and Security Management Service
Jim Bosworth	Joint Commissioning Manager Sutton and Merton Primary Care Trust
Aarti Joshi	Head of Mental Health Commissioning Richmond & Twickenham PCT

Dr Rachel Perkins	Director of Quality Assurance and User/Carer Experience SWLSGT
Tom Clarke	Associate Director of Nursing Wandsworth

Appendix D

Areas for consideration in refining the John Meyer Ward Operational Policy

The following comments and observations are presented in the order of headings in the current Operational Policy. They are intended to help with the refinement of the policy that will in any case be necessary in preparation for the transfer to a new purpose built PICU.

- General presentation e.g. page numbers, grammar, and consistency of terminology.
- Core Functions - excludes reference to unqualified staff.
- Confidentiality - section needs rephrasing in places.
- Equal Opportunities - specific reference to individual assessment of need, access to interpreters and recruitment of staff would be helpful.
- Admission and Exclusion Criteria - Does the admission criteria include Sections 4, 5/2, 5/4 or 136 of the Mental Health Act? Exclusion of this group of patients would need to be made explicit in the Operational Policy.
- Follow up Support - consideration of the advice given when people have not been admitted.
- Admission procedure - needs references to informing staff, the process of admission and the patient's legal status - terminology needs to be consistent. More clarity needed in describing the searching procedure and links to any searching policy and privacy, dignity, right to refuse issues. This section could be better placed in the Care Pathway part of the policy.
- Bed management - a clearer presentation in the order of how things occur might help.
- Care Pathways - CPA context needs early emphasis. No mention of advanced directives for preferred treatment. Flow chart is helpful.
- Ward Organisation and Management -could possibly differentiate between therapeutic and recreational activities.
- Range of Interventions - wording e.g. following "clinically robust and standardised tools" could be clearer.

Addendum

A relative's perspective

Mrs Amanda Patterson, Jason Cann's mother, contacted the South West London Strategic Health Authority after it had considered the bulk of the external review report. The external review team welcomed the opportunity to meet Mrs Patterson to hear her views and perspectives on Jason's care and treatment by the Mental Health Services.

Jason's solicitors had commented on behalf of Jason and Mrs Patterson on the draft summary report of the internal inquiry. It was agreed that Malcolm Barnard, the external review team leader, would meet Mrs Patterson at her home with Chris Carter the interim chief executive of the South West London and St George's Mental Health NHS Trust. Mrs Patterson was supported at the meeting by her friend Linda Bailey.

Mrs Patterson felt that the Trust's internal inquiry had been comprehensive but that it lacked the perspective of Jason's family. She emphasised that the incident had devastated her family. Not only had Jason killed Eshan Chattun and been placed at Broadmoor Hospital with no prospect of returning home for many years, but there had also been other serious and distressing consequences for the family. Mrs Patterson wanted it made clear that there had been two victims of this tragedy - Eshan Chattun and Jason.

Mrs Patterson told us that she felt strongly that Mental Health Services had let Jason down. He should have been safe at Springfield Hospital but he was not and as a result Eshan Chattun died and Jason's liberty had been taken away with no date set for his release.

Comment

We confirm that both Jason and Eshan were indeed victims of this tragic incident - this was also made clear in the internal inquiry report. We agree that Jason was taken to Springfield Hospital as a place of safety and that the incident should not have been allowed to happen in a secure environment.

Mrs Patterson was also very concerned that drugs should have been found in the bloodstream of a member of the Trust's staff on the night of the incident. This had emerged during Jason's trial. Chris Carter confirmed that this had been referred to in the internal inquiry report. Mrs Patterson accepted that the failings of the service had been comprehensively identified in the internal inquiry - for example, the failure to supervise Eshan that night, the failure to do the required 15-minute checks, the misuse of the lobby area and failure to adhere to the seclusion policy and the poor exercise of clinical judgement in respect of administration of medication - all had been covered in detail. However, Mrs Patterson remained concerned that the question of drugs in the bloodstream of a member of staff in whose care her son had been placed had not been adequately pursued. She suggested that all staff should be subject to routine random drug tests as a deterrent, similar to what happens with some schools and other employers.

In light of Mrs Patterson's concerns and views the external review team examined the Trust's current policy relating to substance misuse by staff. We also looked at the national NHS policy guidance and at the report of the 2004 report independent inquiry into drug testing at work.

Trust policies on drugs and alcohol at work

The current Trust policy is entitled "Alcohol at Work Policy Guidelines for Managers". It is dated September 1992 and was due for review in November 2003. The Trust's director of Human Resources has confirmed that this is the current policy. Work is underway to update and re-write the policy. However no drafts were yet available for us to read. The lack of resources in the HR function in the Trust had led to delays in

updating the policy as work on other policies for example related to bullying and harassment had taken precedence.

Comment

The Trust's policy for the misuse of alcohol and drugs in the workplace is out of date and unfit for purpose. It covers only the use of alcohol by staff and does not meet the requirements set by national guidelines.

Recommendation

The Trust should complete the updating and modernisation of its policy covering substance misuse by staff as a matter of urgency. If necessary the internal resources of the Human Resources function should be supplemented by external support to achieve this.

Department of Health and NHS guidance on drugs and alcohol

Department of Health guidance is set out in "Taking alcohol and other drugs out of the NHS workplace" -February 2001. It states: "drug or alcohol misuse by anyone working in the NHS is wholly unacceptable".

The guidance defines substance misuse and outlines the responsibilities of employers, managers, Human Resources Directorates, Occupational Health Services and staff. The employer's responsibilities are highlighted to include "ensuring that a suitable policy and standards are agreed with the workforce in their organisation and are in place and implemented".

The guidance was updated in January 2005 by NHS Employers. The revised guidance adds that "random testing of staff, as a tool for managing substance misuse, is not appropriate for NHS employers". The revised guidance does not include the evidence upon which this conclusion was reached. The external review team therefore sought evidence from other sources to establish whether a proposal to randomly drug test NHS staff could be supported.

Drug testing in the workplace - report of the independent inquiry into drug testing at work

The independent inquiry reported in May 2004. It was undertaken by Drugscope and funded by the Joseph Rowntree Foundation and NEF. The inquiry examined written and oral evidence over an eighteen month period. It heard from a very wide range of representatives of industry, including transport, utilities, insurance, aerospace, coal and telecommunications. It also took evidence from the statutory sector including police, probation and local government and from health professionals, occupational health services, social researchers, trades unions and laboratories and testing companies.

The report summarises the arguments for drug testing in terms of benefits for safety, efficiency, an organisation's reputation and employee welfare. It indicates that the arguments are strongest with respect to safety-critical occupations, where drug induced intoxication can increase the risk of accident. The arguments against drug testing are summarised that it: does not have the benefits that are claimed for it, is excessively invasive, may damage relationships between employers and employees and could hamper the recruitment and retention of good staff.

The inquiry examined the science of drug testing and legal implications and social issues. In a chapter on evidence and costs and benefits the inquiry was unable to find any conclusive evidence for a link between drug use and workplace accidents except for alcohol. The evidence for such a link was inconclusive.

The inquiry report makes the point that while drug testing may have a role in some (safety-critical) industries (such as nuclear generation, coal mining and the underground railway system) it is no substitute for good management. The evidence examined by the inquiry did not demonstrate that drug testing has a significant deterrent effect or that it is the most appropriate way of engaging with staff whose drug use is affecting their work.

The inquiry concluded also that "the key to the successful implementation of drug and alcohol policy is that it is conceived as a component of health and welfare policy and not, at least not primarily, as a disciplinary matter. A drug and alcohol policy will be effective only if it is negotiated with and accepted by staff across the organisation." The report goes on to state that one of the strongest themes to emerge over an 18-month period was that good all-round management was the most effective method for achieving higher productivity, enhanced safety, low absentee rates, low staff turnover and a reliable and responsible workforce and added: "For the majority of businesses, investment in management training and systems is likely to have a more beneficial impact on safety, performance and productivity than the introduction of drug testing at work."

Comment

We understand Mrs Patterson's concerns that everything possible should be done to prevent NHS staff from misusing drugs but we do not believe on the evidence that the introduction of random drug tests for NHS staff would be effective as a deterrent or cost effective. We agree with the independent inquiry that good management and a sound policy framework agreed by all parties is likely to be the most effective solution.

We were most grateful for the opportunity to listen to Mrs Patterson's views, perspectives and concerns and to be able to reflect them in this addendum.

References:

Alcohol at Work Policy Guidelines for Managers	SWLSGT	Sept 1992
Taking alcohol and other drugs out of the NHS Workplace	Dept of Health	Feb 2001
The management of health, safety and welfare issues for NHS staff	NHS Employers	2005

Drug Testing in the Workplace- Report of the Independent Inquiry into Drug Testing at Work	Rowntree Foundation	May 2004