Dorset Healthcare University NHS Foundation Trust

Audit Committee Inquiry into Possible Governance Failings relating to Minterne Ward, Forston Clinic

Background and Purpose of the Inquiry

The Care Quality Commission carried out an inspection of Minterne Ward in November/December 2012, which concluded that the ward was not meeting the essential standards in the 10 areas that they inspected. The Trust has responded with a detailed action plan and also has decided to close the ward while rebuilding work and retraining of staff takes place.

The inspection referred to above followed previous inspections in June 2011 and January 2012 where CQC also found that some standards were not being met. Other key events having a bearing on this issue are -

- an in-patient suicide in February 2011
- a serious safeguarding incident in April 2012, which was brought to the Trust's attention by a staff "whistleblower". The Trust commissioned an external review, which was shared with CQC.
- Coroner's Rule 43 letter in May 2012, concerning the suicide of a community patient, but with implications for the way serious incidents had been managed in DCHS

The Audit Committee is concerned to establish where the governance systems failed in this process. It needs to understand what the Trust and its Board knew at various key points and also what it reasonably ought to have known. The Committee also considers that the robustness of executive management systems is an integral part of the Board assurance programme and the effectiveness or otherwise has formed an important part of this inquiry. The inquiry has focused on the period immediately prior to the acquisition of the Community Health Services to the end of 2012

Methodology

- The Chair of the Audit Committee provided a briefing document to the executive team, outlining the primary areas of concern in relation to governance and management systems.
- The Audit Committee received a comprehensive response document from management with a detailed chronology, line by line analysis of the CQC inspection outcomes, initial management conclusions and recommendations

- The Committee held 2 face to face hearings, with the following executive members present, Chief Executive, Medical Director, Director of Quality, Finance Director, Director of Adult Mental Health
- The Chair of the Committee also conducted extensive desk research as follows
    - Earlier CQC reports
    - Report by external consultant into the safeguarding incident
    - Board Meeting minutes from January to December2012
    - Quality and Clinical Governance and Risk Committee minutes for the same period
    - Executive Management Team minutes for the same period.

The above indicates that the resources of manpower and time have been limited in this exercise and the Committee has sought to concentrate on key themes.

Pre-acquisition period

The key questions –

- *Was the due diligence process adequately specified?*
- *Were there any issues brought to the Trust's attention, during the due diligence process or as a result of the extensive pre-acquisition contact and dialogue between the Trust and DCHS?*
- *Did the Trust make appropriate enquiries as to specific clinical standards at ward level?*

Prior to the completion of the acquisition the Trust commissioned a Clinical Due Diligence report from the legal firm, Capsticks. This process relied on an examination of risk and governance systems and no visits were made to any DCHS units. Nothing came out of this process that indicated a cause for concern at Minterne Ward.

The Due Diligence process was not sophisticated and was possibly misleading; RAG ratings were all detailed as green. These were compiled as a result of internal self-assessment by CHS personnel and without triangualation by Capsticks with other information. At no point was the Acting Chief Executive (substantive Director of Finance) informed of any concerns. The Primary Care Trust was both commissioner and manager of the DCHS organisation. The PCT did not inform the Trust of any concerns relating to Minterne Ward.

There does not appear to have been any specific action by Trust management to verify the clinical standards at the CHS units, with the exception of an audit on compliance against NICE standards, which did not pick up issues of major concern. The assumption was that 3 high performing organisations were being brought together. There were numerous Board contacts, both at executive and non-executive level prior to the acquisition, and there was no concern registered about clinical standards at the in-patient Mental Health units.

Audit Committee opinion.

In terms of what we knew and were able to observe at that time, it was not felt necessary to commission any independent verification. It is the view of the Committee that this was a reasonable position to adopt. It is our understanding that this was an approach adopted by most Foundation Trusts going through this process.

Immediate post-acquisition period ("the first 100 days"+)

The key questions –

- *Did the Trust Board adequately risk assess the "acquisition" process in the light of the situation at the time and the information available to it?*
- *Was management process and board scrutiny sufficiently rigorous to ensure adequate levels of patient care?*
- *Were steps taken to make an early assessment of clinical standards, particularly at the key in-patient units (and notably Minterne unit)?*

As part of the planning for consolidation of the acquired units, it was decided that any major re-organisation would be put on hold for six months, while the Trust gained a full understanding of the services acquired and an optimum organisational structure was designed. A number of factors impacted on the effectiveness of this process.

- The Trust was acquiring two complex organisations, with a combined turnover far in excess of its own. Also these organisations were working within a culture very different from that of a Foundation Trust.
- The two new organisations were operating in many service areas unfamiliar to the Trust. The Mental Health services were also conducted in a very different way to that in the old Dorset Healthcare
- The Trust would not have been able to fully assess the capability of the CHS management.
- The Trust's long-standing and experienced Chief Executive was on a period of long term ill-health absence.

From the acquisition in July until the new management structures being put in place in January, DCHS was still acting as a separate organisation within Dorset Healthcare. Although DCHS reported to the Executive Management Team, separate committee meetings were operated. Therefore, in effect, the organisation was left in isolation for six months, with a disconnect in terms of governance systems. Management focus and Board scrutiny was more directed towards organisational and structural issues rather than clinical performance.

Separate Quality and Clinical Governance committees were continuing to operate in DCHS. Although a Trust Director of Quality was appointed in September 2011, there was no pooling of quality processes until January 2012.

The Director of Mental Health for DCHS was not properly integrated into the Dorset Healthcare Mental Health senior team, and as a result the Trust line management did not establish rigorous management disciplines. There was reliance on information being fed up the line, rather than seeking first-hand assurance. This was also the case at Board level with

no particular sense of understanding of the level of corporate risk attaching to this acquisition.

Early site visits were made by the Medical Director who confirmed to the Board that he had been impressed by the staff he saw on the wards but noted a huge difference in operation between east and west; the east had a very different model of care.

The Trust does not appear to have engaged in any systematic process of assessing clinical performance against CQC standards. This is surprising, certainly in the case of Minterne ward, given that, by this time, the Trust would have had sight of the June 2011 CQC report, and an awareness of an earlier in-patient suicide incident. The Trust also by this time would have had the opportunity to review the recommendations of the coroner.

The issue of staffing levels at Minterne ward had been a topic of discussion and concern within DCHS prior to the transfer and was brought to the attention of Trust management at an early stage. Changes and improvements were to be addressed as part of an urgent care pathway, however this continued to be delayed by public consultation and judicial review.

The Audit Committee had reviewed the Trust Assurance Framework in light of unfamiliarity with the range of new services and possible risks associated with that and requested a piece of work to be carried out jointly by Internal Audit and the Quality Directorate, to strengthen the "ward to board" assurance process. This resulted in a "quality dashboard" being incorporated into the Quality Reports going to the Board.

Audit Committee opinion –

The Board did not adequately assess the risks attached to this acquisition process. Priority should have been given to ensuring that the management resources, systems and governance processes were secure enough to underpin acceptable levels of patient care. The Board should not have allowed such a lengthy period for the establishment of an effective management structure. The delay brought unnecessary risks in terms of routine management disciplines and transparency of clinical governance.

The Board should have set as an early priority the gaining of assurance over standards of patient care. The reliance on the previous due diligence process and assurances from employees and third parties should never have been enough. The Trust should have requested an "on the ground" inspection at a very early stage, probably within weeks.

Trust management did not adequately triangulate quality signals that were feeding through at an early stage –

- Actions required as a result of inquest on in-patient suicide
- Delays in addressing staffing issues on the ward
- Issues raised in the first CQC report
- Adverse trends in the Early Warning Trigger Tool

This should have resulted in an urgent assessment of the fitness to operate of Minterne Ward

The Trust made a mistake in not taking a more proactive role in managing and consolidating the two new organisations. The "organisation within an organisation" did not work. The "softly, softly", "merger" approach was considered to be appropriate to avoid staff anxiety and de-moralisation, however this has resulted in a far from effective management process and poor "line of sight" in terms of board assurance on quality issues.

Second Phase – January to May 2012 – New management structures in place

Key questions-

- *How effective was the implementation of the revised management structure?*
- *Was the Trust response to the January 2012 CQC report adequate?*
- *Did the report and subsequent action plan process get appropriate exposure and response in the governance structure?*
- *Was the implementation and effectiveness of the action plan properly managed?*

The revised management structure was finally put in place in January 2012, with a Director of Adult Mental Health assuming responsibility for county-wide services. A Director of Quality and an Executive Director of Nursing were also appointed. The Chief Executive returned to work in September 2011 and retired in February 2012. The new Chief Executive was appointed in February 2012.

The process of establishing top level management structures had taken at least 6 months, during which time little progress had been made on "transformation" and management and governance systems were less than fully effective. It appears that during this period the new Adult Mental Health directorate management group (DMG) meetings were dysfunctional, with a large number of attendees and minimal input from ex DCHS managers.

The Trust Quality and Clinical Governance committee was split into separate "operational" and "assurance" committees, with the latter chaired by a NED. From examination of minutes it does not appear that issues at Minterne were adequately examined and insufficient attention was given to timely completion of action plans or scrutiny of improved patient care outcomes.

The second CQC inspection visit was in January 2012, with the draft report received on 2nd March 2012. No verbal feedback was given by CQC at the time of the visit. The report, in itself, was not considered by senior management to be particularly alarming, with 3 minor and 2 moderate concerns, although it is worthy of note that Dorset Healthcare had not previously received reports with moderate concerns. It should have been of concern that a number of issues were of the same or similar nature to those picked up in the previous June 2011 report. This should have resulted in a more intense level of scrutiny by management, governance committees and the Board. The action plan was drawn up by the DCHS Director of Mental Health and signed off by the Trust Director of Adult Mental Health. It appears that

there was insufficient scrutiny and challenge as to the appropriateness of the action plan and the likely effectiveness of its implementation.

The Chief Executive's report that went to the Part 2 March Board meeting acknowledged receipt of the draft report and the action plan was reported to the Board in May. The report to the Board reflected an assessment that the issues were disappointing but not considered alarming. The Board noted the Chief Executive's report and in May noted the action plan but did not request follow up. Full CQC reports used to go the Board but from April 2012 the process changed and only a summary was provided with the high level report going to the Assurance Committee, which convened every two months. There would have been reference to it at the Quality, CG and Risk Assurance Committee, but the Committee would not have received the full report. Again committee minutes note the report and action plan but do not indicate a request for follow-up or confirmation of improved standards.

Audit Committee Opinion –

The final management structure did not fully integrate DCHS into the Adult Mental Health directorate as a result of unresolved HR issues. Quality assurance processes were sub-optimal with, firstly dual committees of "operational" and "assurance" and then a combined committee with too large a list of attendees and an unwieldy agenda. "Line of sight" from Board to ward was obscured by this situation.

Line management again did not triangulate various quality signals and indicative information (eg early warning trigger tool), which should have resulted in a more urgent approach to resolving the issues on Minterne Ward.

Action plans were not properly scrutinised, and follow up processes were inadequate to ensure changed behaviours and outcomes.

Third Phase – May to December 2012

Key Questions

- *Was the response to the "safeguarding" incident appropriate?*
- *How was the Trust managing the CQC process?*
- *Was the flow of information to the Board timely and appropriate?*
- *How effective was the quality assurance process?*
- *Did the Trust adequately manage the "change process" in Minterne Ward?*

The Director of Mental Health for DCHS retired from the Trust in June 2012

The Trust received a "rule 43" letter from the coroner in respect of an earlier suicide. Although this related to a community patient, it alerted the Trust to a number of poor governance practices within the old DCHS organisation.

The Trust was also informed in May, via a "whistleblower", of a serious safeguarding incident on Minterne Ward which had occurred in April. The incident related to

inappropriate use of restraint on a patient with particularly challenging behaviour. The Trust took prompt action in terms of removing certain key staff from the ward. In June the Trust commissioned an external consultant to examine the circumstances surrounding the episode and to put forward recommendations for change. A draft report was received in July with the final confidential report received in August. This final report was shared with Safeguarding Board colleagues and CQC.

The report was very critical of standards on the unit and raised serious issues of staff competence and attitudes, clinical and managerial leadership, training processes as well as suitability of the clinical infrastructure.

The Trust management would have been aware of the key conclusions of this investigation in July, however the Board was not alerted to the seriousness of the situation until brought to the attention of the Quality and Clinical Governance committee (Board sub-committee, chaired and attended by NEDs) on 21st August. This item was at the end of a very long agenda and the minutes show the following

"JB advised that the Trust has now received the external review into concerns raised through the Trust's Whistle blowing Policy about an incident on Minterne Ward. An action plan is being developed and this will be presented to the next meeting of this Committee with the full report. In the meantime, it was agreed that JB will verbally brief the Board at Part 2 of the September meeting."

The Board did not receive a copy of the report at this time.

The Chief Executive reported in his September Board Report as follows

"The Trust has now received the full report into the care and treatment of a patient on Minterne Ward at Forston Clinic. The Trust is producing an action plan in response to the report and has also taken action against a number of individuals indentified in the report. The report and action plan will be presented to the October Quality, Clinical Governance and Risk committee."

and a verbal report to the September Board meeting on the CQC actions was reported in the minutes as follows

"Mr ------ informed the Board that following the Care Quality Commission's report on Minterne Ward, he considered that the practices on the ward were not acceptable and below the standard the Trust would accept. There was evidence of poor leadership relating to senior medical and nursing input and a culture of demotivation. This was now improving; the new team was focusing on getting the right culture and leadership and going back to first principles through improving training and education. The appointment of a new full time Psychiatrist would contribute greatly to sustained improvements.

*Mr ***** commended Mr -------- for his quick and appropriate actions."*

The report and action plan on the safeguarding incident was presented to the Quality and Clinical Governance Committee on 23rd October. These issues were discussed and the actions noted. This was minuted as follows

"The Committee was pleased to receive the report which outlines the findings of the external review and fully supported the action plan to address the issues found. GF was pleased it was such a focussed report but was anxious that the seclusion facility is dealt with as a matter of urgency. LMW advised following discussion with JB the key issues were to bring the seclusion room up to the required standard, to have robust monitoring of seclusion, and get clarity with commissioners that Minterne is not an intensive care unit.

PS acknowledged this issue has been a long ongoing saga but felt it is important to recognise the organisational positive learning and good practice:

- *the quality of the external investigation linked to the whistle blowing alert, and encouraging staff to report*
- *the proactive stance taken by JE with regulatory agencies*
- *the proposal to put backfill into Minterne so the entire team can have a learning day out."*

Audit Committee opinion –

The Trust had an awareness of the seriousness of the safeguarding incident in May, and together with the shortcomings found by CQC, the coroner's letter and other adversely trending quality indicators, this should have triggered a substantially more urgent response to evaluating the "fitness for purpose" of the ward and putting in place an urgent corrective action response, backed by the Board. The external report should have been a third party corroboration of the Trust's own findings.

The Board should have been alerted to the seriousness of the situation earlier and when it was alerted should have adopted a more urgent, robust and challenging stance to secure the quality of patient care and full compliance with CQC minimum standards. Board meetings have been changed to every other month. There was no meeting in August and no agreed escalation process is in place to bring critical matters to the Board's attention outside of Board meeting processes. In the absence of this, the Board needs to rely on the judgment of senior management to raise such matters in an appropriate way.

It is commendable that the external report into the safeguarding incident was shared with external bodies including CQC, however management should have been alert to the substantially heightened awareness of CQC to the shortcomings at Minterne and this should have resulted in an absolutely "no tolerance" approach to any possible breaches of CQC standards, and a "highest level" attention to securing to securing this.

Management and the Board believed that the new senior staff on the ward would see the action plan through to completion. The Board should have ensured that management provided close supervisory support to ensure these employees would be successful in their new positions.

Again, the Trust approach to the robust and timely completion of action plans fell short of acceptable standards. It is important to ensure that the action plan makes a positive difference to the outcomes for the patients.

The Quality and Clinical Governance and Risk Committee as currently structured does not appear capable of giving the Board appropriate assurance on key patient care issues. Its agenda is far too cumbersome and overly burdened with operational issues.

Conclusions

- The Trust underestimated the risks associated with a large and complex acquisition.
- The Trust was not rigorous in establishing clinical standards across its new areas of responsibility
- Management restructuring was far too slow, and in itself heightened the risk
- Quality governance systems were disconnected and the Board did not have comprehensive "line of sight" through to clinical operations
- Quality information for the enlarged trust was not mature and not properly triangulated to give early warning to the Board
- Management of action plans was poor and Board scrutiny inadequate
- Critical patient safety issues were not fed through to the board in a timely and appropriate way.

Recommendations

- On any future acquisition, consider procuring external help from acquisition specialists
- When taking on any new service, the establishment of acceptable clinical standards to be a "first 30 days" priority
- Establish management structures rapidly and decisively to ensure clear lines of responsibility and accountability
- Restructure Quality and Clinical and Risk Governance assurance process, to ensure focus on key patient care issues and to provide reliable assurance to the Board
- Ensure Audit Committee conducts a more regular rigorous appraisal of the effectiveness of the assurance framework relating to patient care issues.
- Establish a protocol for the scrutiny and management of action plans
- Establish a protocol for escalation of issues to the Board
- Ensure Board agenda allows adequate time for presentation and discussion of key third party assessments