Independent Review of Adult Mental Health Services in Jersey – which are part of the Health and Community Services (HCS)

By

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and Simon Pyke

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1. Introduction

This review has been commissioned by the Executive Team of Health and Community Services at the behest of the Department's Quality and Safety Group. It covers the area of Adult Mental Health Services in Health and Community Services. This includes both Community and inpatient services and acknowledges the interface with particularly, Drug and Alcohol services and Older Adults Mental Health Services.

2. Terms of Reference

2.1. Background

Health and Community Services (HCS) are committed to provide safe and sustainable services that improve outcomes for people who use services and their families. As part of this ongoing commitment, HCS wish to undertake an external review on the quality, safety, standard and design of the local Adult Mental Health Services.

Currently not all HCS are subject to inspection by an independent regulator, such as the Care Quality Commission in England, therefore, external independent reviews aim to provide the executive team, multi-disciplinary team, managers, people who use services and the public with assurance that they can be confident in the quality and safety of the services delivered by HCS.

The process will provide a valuable objective judgement about the services and performance, assessed against national clinical/social care and professional standards.

Advice will be given on the current model of service design and configuration and any remodelling of service required to meet future needs and development of new ways to improve care for people who use services and their families.

2.2 Aim and Scope

The overarching aim is to make sure the services provided by HCS are as safe as they possibly can be, whilst providing care and quality standards within the context of a small island. We aim for the department to be an inspiring place to work and to promote productive interprofessional relationships so that people who use services can be seen by the most appropriate person at the right time and in the right place.

The process will be encouraging and supportive, providing honest and candid feedback even if that may be uncomfortable or difficult to hear. Good practice will be recognised, and any weaknesses or issues identified will be shared in a supportive and constructive way.

The reviewer/s will ensure that during the process, all interviewees understand the confidential nature of the review but that their reflections and information shared, may be used within the report, albeit in an unattributable way, and backed up by several other sources of evidence wherever possible.

The independent reviewer/s will act independently of other external authorities to offer advice and recommendations confidentially, in an environment of trust.

Immediate issues of concern will be escalated to the Group Medical Director and to the Executive Directors where appropriate.

2.3. Key objectives

Examine the models and pathways of care delivery within the service and assess whether they are delivered in line with current legislation, standards, and evidence-based guidance to achieve effective and appropriate safe care and outcomes.

Appraise how well people who use services and their family's needs are assessed and if care and treatment is delivered in line with current legislation, standards, and evidence-based guidance to achieve effective outcomes.

Judge systems in place to improve physical outcomes for people who use services in line with 'whole person care', to achieve parity between mental and physical health; including the ability of services to recognise and respond to physical deterioration and joint working between mental health, acute and community physicians.

Evaluate the management structures, model of leadership and the capacity and capability of the service in terms of human resources (including MDT and support functions) and consider whether the current systems of accountability are effective and support high quality, safe and sustainable services.

Assess the culture within the service and whether this enables openness and honesty at all levels, including with people who use services, in response to incidents; considering if the relationships amongst staff teams enable them to work collaboratively, share responsibility and resolve conflict quickly and constructively.

Examine the overall safety of the service and assess the processes for managing risks, issues and performance and monitoring safety, learning and continuous improvement.

Judge what a modern Mental Health service should look for in an island such as Jersey, aligned to local plans in the wider health and social care economy, particularly in terms of workforce and especially for the medical workforce, taking into consideration the needs of the planned and unplanned aspects of the service.

Highlight areas which positively contribute to the service which should be supported and maintained through any changes.

Identify how an island such as Jersey could link into a network to help enhance and support the quality and safety of the on-island services.

3. Executive Summary

This review was undertaken at the request of the Health and Community Services Department's Executive Team and was tasked to give a judgement on the overall safety of the service and how it was led and managed together with other key objectives as described.

The reviewers had access to a number of documents and information from the service and undertook field visits to services across both community and in-patient services and interviewed several staff between the 29th of September 2021 and the 2nd of October 2021.

This was then collated and, where possible, tri-angulated to provide evidence guiding the report.

The reviewers found the following key issues within Adult Mental Health Services:

- There is a lack of senior management leadership and direction.
- A lack of a system of MDT working such as the Care Programme Approach or an equivalent.
- Within Adult Mental Health, there are inadequate systems to learn from Serious Incidents.
- Silo working professionally and within teams.
- Lack of a system to ratify, manage and implement policies and procedures.
- Poor management supervision structures.
- Within Adult Mental Health on a positive note, the reviewers spoke with many professional staff who had a real motivation to develop and improve the service and have the potential to achieve positive change. Inpatient services have made some recent improvements but further work is required.

The reviewers have identified several recommendations which focus on the key issues which it is hoped can be used as a springboard to help develop the Adult Mental Health Service that Jersey deserves.

4. Recommendations

The list of recommendations is not meant to be exhaustive but to focus on the key issues facing Adult Mental Health Services.

1) Adult Mental Health Senior Management Structure

I) Review the senior management structure within Adult Mental Health Services to ensure it is fit for purpose.

II) **Make sure that Adult Mental Health Services have clear objectives that are regularly reviewed.**

III) **Define and ensure measurable mental health outcomes, such as improvement in symptoms or functioning of patients. This might initially have to be process driven, for example by introducing the Care Programme Approach) introduction, and the number of MDT reviews undertaken.**

IV) **The Adult Mental Health Service is in the process of integrating with Adult Social Care –Consideration should be given to putting this on hold until such time the Adult Mental Health Service is considered safer.**

2) <u>CPA or Equivalent</u>

Adult Mental Health Services must introduce a system of CPA or an equivalent, acknowledging that this is more than a policy and requires a clear project plan that must include training for staff. It is important the staff group are involved in the development of this along with patients. The aim is to ensure good communication between clinicians, teams, patients and relatives.

This must include a clear method of MDT working.

Utilise best practise from other services in the context of an island service.

3) <u>Jersey Care Model</u>

Jersey has an ambitious plan to develop services in line with its model of care.

Adult Mental Health Services need to develop in the context of this with a clear model of care that is understood across the whole Jersey Health Service. Adult Mental Health Management structures should follow from the chosen care model and objectives that ought to be clearly defined with measurable outcomes.

Initially the current model needs to be articulated as a whole system so that each component part is understood as part of a whole system rather than a silo.

4) <u>Adult Mental Health Management Roles</u>

The management roles within Adult Mental Health Services should be reviewed to ensure that they receive regular management supervision, have clear objectives, and understand their role as part of a holistic Mental Health Service. The meeting structure should be reviewed as part of this to ensure it is fit for purpose and effective.

The [redacted] should have a clear link into the Chief Nurse Office and hierarchy, which influences and monitors the job plan. The role of the [redacted] should be reviewed and defined in line with the Jersey Care Model and best practice.

Consideration should be given to having the legislation department under the remit of a general manager within Adult Mental Health Services, rather than the current structure which reports to an adult social services manager.

5) <u>Policies and procedures</u>

There must be a clear process for developing and agreeing policies within the Adult Mental Health care group, and where there are delays, there must be an escalation process to the Mental Health leadership team

An overall Clinical Risk Management Policy is a priority for Adult Mental Health

We were told that there is currently a protracted process to deliver Electroconvulsive Therapy (ECT) for patients in Jersey, which does not allow for urgent ECT to be commissioned. There should be an agreed pathway for Electroconvulsive Therapy. As a matter of urgency, emergency ECT provisions need to be planned and commissioned, which should be in line with best practise guidelines.

Other immediate policies have been flagged earlier

6) <u>Community Mental Health Team (CMHT)</u>

The CMHT should consider that its staff should work across clear catchments areas on the island. This will allow coherence and fair distribution of workload.

Further consideration should be given to ensure that in particular, mental health nurses and social workers undertake community visits as appropriate.

7) <u>Consultant Psychiatrists</u>

The consultant job plans should be reviewed to ensure they facilitate MDT working and are in line with point 6 above.

Job plans need to be in line with Royal College of Psychiatrists recommendations. This will have to include management time for the senior management team.

Also, there should be a clear process that audits the use of polypharmacy to ensure it is in line with best practise. The role of the pharmacist could help facilitate this.

8) Adult Mental Health inpatient services

The model of care in the Adult Mental Health inpatient wards should be reviewed to ensure effective MDT working, continuity of care between inpatient and CMHT services, and to ensure there is a clear emphasis on safety and therapeutic interventions.

The inpatient services would benefit from an overall improvement plan linked to recommendation 9.

9) RCP accreditation/Best practise

Consideration should be given to joining the RCP (Royal College of Psychiatrists) networks across a range of specialities in mental health and working towards accreditation in each area as well as using the networks to maintain best practise and share learning.

Consideration should be given as to how key personnel within Adult Mental Health can receive adequate support and guidance to help them develop mental health services and understand best practise.

10) Communication

There needs to be a clear communication process in Adult Mental Health that informs and allows staff to feel involved in the development of services.

5. About the Authors

Prof Lepping is a clinical psychiatrist and researcher who works as a Liaison Consultant Psychiatrist in Wrexham, Wales. He went to University in Münster (Westphalia). He did his postgraduate psychiatric education in and around Liverpool. He received a Masters in Medical Ethics from Liverpool University in 2003 and won several research prizes. He has CCST accreditation in Adult and Liaison Psychiatry.
From 2004 he worked as a consultant in North Wales, first as a community psychiatrist and since 2017 as a liaison psychiatrist. He developed specialist clinics for adults with ADHD in Wrexham, as well as an internationally renowned clinic for delusional infestation with the School of Tropical Medicine in Liverpool.
He has appointments as Honorary Professor with Bangor University in Wales, and Mysore Medical College and Research Institute in India. He has been a member of the European Violence in Psychiatry Research Group (EViPRG) since 2005, and contributes to initiatives for the prevention of violence and coercion.

His research interests include delusional infestation, coercion, violence and aggression, clinical ethics, capacity, ADHD, systematic reviews, and various other projects. He has published one book and contributed to several other books, as well as publishing over 160 articles, correspondences, and abstracts.
He has led and participated in many service reviews, expert reports, and incident reviews nationally and internationally.

Simon Pyke trained as an RMN, RGN and has an MBA and who recently retired from the NHS where he was Associate Director of Operations for Mental Health and Learning Disability services. Since retirement he has worked for the CQC as a specialist advisor and for Her Majesty's Inspectorate of Prisons as a Healthcare Inspector. He has also undertaken several serious incident and governance reviews across the UK.

He is also a non-medical reviewer for the Royal College of Psychiatrists invited review service.

6. Methodology

The reviewers received information from Adult Mental Health Services and this was followed up by several interviews with staff and visits to service, reviews of medication charts and a review of some clinical records. This was then further collated against best practise guidance from across the UK , together with the specialist knowledge of the reviewers. This information was then triangulated wherever possible to provide the evidence for the review.

7. Review limitations

The Review team spent three days visiting the services and interviewing a large number of staff. There was not sufficient time to observe clinical teams as they work or to fully review each individual aspect of the service, and ideally more staff would have been interviewed. The review w not able to interview or meet with patients as there was an issue with attendance, and only had limited contact with carers/relatives.

However, this does not detract from the overall findings and recommendations from this review

8. Background information about the service

Jersey has a population of approximately 108,000 and it is acknowledged there is a high cost of living associated with the island and there are known areas of deprivation. Alcohol consumption rates are among the highest in Europe.

Statutory Adult Mental Health Services are part of the overall Health and Community Services on the island. Adult Mental Health Services are in the process of being integrated with Adult Social Care under the Government restructure and target operating model which commenced during 2019.

Child and Adolescent Mental Health Services are managed through the Department for Children, Young People, Education and Skills (CYPES), although the CAMHS psychiatrists link into the Associate Medical Director for Children and connect with the overall Psychiatry group.

Adult Mental Health Services have inpatient services based on a site away from the general hospital located on the grounds of the former St Saviour's Hospital. This is Orchard House as the adult inpatient ward (14 beds) within the island context. On occasions it receives specialist admissions, e.g., patients with Forensic, CAMHS, Perinatal, Eating Disorder and Learning Disability needs. There is a functional inpatient ward for older people, Cedar (14 beds), and a ward for people with organic mental health problems, Beech (10 beds). It was noted there could be flexibility of usage across Orchard House and Cedar Ward.

There is a base for the community adult mental health team (CMHT). The Crisis resolution/Home treatment is based elsewhere. This also contains a community triage team who work alongside the police. Within Adult Mental Health there is a Psychological Therapy service, Jersey Talking Therapies, and the Listening Lounge, which runs independently of Adult Mental Health services, providing primary care counselling.

There is a psychiatric liaison service into the general hospital.

The management of Adult Mental Health Services is through an Associate Medical Director and an Associate Managing Director. There is also a general manager who reports to the Associate Medical and Managing Directors (AMDs), a lead nurse for community and an acting lead nurse for inpatients, both of whom report to the AMDs There is an Associate Chief Nurse who provides professional support to the Lead Nurses. HCS are currently out to recruitment for an Associate Chief Nurse for Mental Health; this is the second time the post will have been advertised. . There is also a lead Allied Health Professional post within the service.

Jersey has approved a new model of care (JCM), which has an emphasis on a joined-up service between physical and mental health where both are seen with parity, with an emphasis on community provision. This is in line with modern health services elsewhere.

Several people who we interviewed commented on a previous bullying culture in Adult Mental Health Services. This had been addressed and had improved considerably. More work needs to be done to develop and maintain this improvement.

9. Findings and Supporting Evidence

I. Leadership of the Service

The service is led by an Associate Medical Director (AMedD) and an Associate Managing Director (AManD). There is also a clinical lead post for the psychiatrists. There is a general manager post that reports to the AMDs.

There are two lead nurse posts, one for community and one covering in-patient services.

We were informed that at an AMD level the functions were split with the AMedD taking a clinical lead strategically and the AManD manager taking a lead operationally. There is a General Manager who supports both of these posts.

We reviewed various minutes of meetings and talked to staff throughout the review to ascertain how this system worked, and it soon became clear to us that it doesn't work very well. There is a lack of clarity of purpose and substance of content in the various meetings that the service has. There is a lack of accountability, both individually and collectively.

Suffice to say there is a clear lack of direction in the Adult Mental Health service and a lack of management processes. This has led to a silo mentality amongst managers in Adult Mental Health and staff. Modern Mental Health Services must work as a cohesive unit, this is clearly not the case in this service. Instead, good services usually exist despite the Adult Mental Health management structure because of silo working (for example, substance misuse services).

The model of care in Adult Mental Health is split into component parts and is further split into professional groups.

We saw several improvement/action plans in Adult Mental Health which are reported to be progressing, in most cases they are not, an example of which is policy and procedures where often they are reported as progressing, but they fail to be ratified. This is because the wrong people are asked to produce and ratify various policies, or because the quorum to ratify is rarely reached, or because staff are actually unclear what the process for ratifying policies is. There is a real danger that the HCS Executives are given false assurance on progress. Minutes of meetings held in Adult Mental Health are hard to follow and in key areas of governance attendance of key meetings by the relevant individuals is at best sporadic.

This is a lack of clear objectives for services and individuals, and we struggled to get information to ascertain if individuals received management supervision; it appeared that for large parts of the service staff did not receive ongoing supervision.

There is an Adult Mental Health Service improvement plan and the reviewers felt this was not progressed adequately, and it remained unclear how it was effectively managed.

The communication lines seemed poor, which is further compounded by a lack of direction and management.

Consultant Psychiatrists reported having their job plans changed by the AMedD and the Clinical Lead at short notice and without proper consultation. It was felt by the reviewers that this was probably a reactive response to need that was compounded by a lack of strategic direction.

serious incidents that occurred in Adult Mental Health were reviewed as part of this work, and specific themes were noted particularly around the lack of a care programme approach or equivalent (this is further addressed in this review) and clinical risk management. These issues had not been addressed. We could not find a process within Adult Mental Health as to how these where actively managed or how learning was promoted.

We saw first-hand that several policies had not been ratified or were classed as in progress, and that the process for ratification was unclear. Although there was a meeting in Adult Mental Health where this could have occurred, it rarely functioned.

1. The absence of senior leadership direction in the Adult Mental Health service has further led to a silo mentality across the service, either by professional group or by service. This has led to decisions being made in isolation, and it has fostered inter-professional rivalries. This is not to say managers within the Adult Mental Health service are not committed or motivated to develop and improve services, but a lack of direction and key clear strategic goals and objectives within a clear supervision framework
2. A safety culture was poorly developed and not embedded across the service, and there was a clear of lack of learning from serious incidents.
3. Care Programme Approach (CPA) or equivalent
   The aim of the care programme approach is to promote the effective liaison and communication between staff, partner agencies, patients and their carers to enhance and coordinate patients' recovery focused care plans, and to ensure all aspects of safety are addressed through collaborative risk assessment and management.
   The key principles of this are a thorough ongoing assessment leading to a formal risk assessment, the development of a care plan and a review of that care plan with the professionals involved, partner agencies and patients, carers, and families as appropriate. CPA was introduced in England in 1991, and is there is an equivalent in each of the countries of the United Kingdom. Serious incident reviews have highlighted CPA or an equivalent in Jersey as a key risk, however, this has not been introduced and it is unclear how this process is progressing.

This is a major risk for the service and needs to be prioritised in order to avoid further incidents.

It should be noted that the introduction of CPA will not eliminate risks in the services, but it will give them a framework to be managed more effectively.

4. Adult Mental Health Governance including policies and procedures

In relation to policies and procedures the reviewers were concerned that a number of policies had not been produced and were cited as in progress on governance updates. The process for ratifying these documents had broken down, so even if the policies had been produced it would not have been possible to have them agreed.

Immediate concerns during the review were raised regarding the lack of the following policies. Please see the Addendum for details of how these were resolved.

A. Clozapine Policy
B. Rapid Tranquillization Policy
C. Protocol for anti-psychotic medication in dementia

Of further concern despite having the issues raised in previous reviews, for example the review by Essex Partnership Trust, there are several other key policies which have not been produced.

These are

- CPA (see above)
- Clinical Risk Management
- Seclusion (There is a policy from 2006)
- Physical Health Management
- Managing Violence and Aggression

This list is not exhaustive.

The process for how policies are produced within Adult Mental Health seems unclear and lacks a clear project plan and process. They were often tasked to individuals who did not have the requisite skills to do this.

II. <u>Adult Mental Health Management capacity</u>

The reviewers interviewed several managers across the Adult Mental Health service and a key theme that came across was how busy everyone was. The reviewers felt this was compounded by the lack of clear management process such as supervision, as many managers reported not having regular supervision; in addition, we saw little evidence this took place formally. This is also linked into the lack of overall direction from the Adult Mental Health service. The subjective sense of feeling busy was notable despite a high staffing level compared to other UK services, hinting at

subjective stress compounded by poor management and organisational structure within Adult Mental Health.

We noted the existence of several key meetings across Adult Mental Health Services, but attendance was often sporadic, and the issues detailed in point 1 regarding the problems with the senior leadership of Adult Mental Health Services compounded this issue. Many managers felt the service lacked direction and felt frustrated they had to work in isolation and unsupported. The level of frustration expressed by some managers was in danger of alienating them from their line managers and staff, and thus losing the context of the issues they were raising.

On a positive note, we did interview several managers who were very professional, wanted to improve services and make them safer.

The reviewers noted that within Adult Mental Health there are several management support posts, whose roles lack clarity and suffer from a lack of clear objectives, performance management, and a lack of clear formal supervision. The reviewers felt that overall, the management capacity in Adult Mental Health was not used effectively and further contributed to the silo working across the service.

Many of the posts in Adult Mental Health were of an acting up status, leading to insecurity and poor clarity about the role.

The reviewers feel there is enough management capacity in the Adult Mental Health Service but lack co-ordination and clarity of role.

III. Orchard House

The reviewers visited Orchard House on two occasions, however, on the second visit the ward had a high acuity level because of This made it difficult to undertake a full review against the RCP Standards for Acute Inpatient Services for Working Age Adults. Despite this limitation, the reviewers used it as a reference point for their review.

It was noted that the ward is due to move to new premises on the site in the near future. It was very evident that the outside of the unit and its proximity to the old, closed hospital is not very appealing.

The ward felt very austere and cold in its décor and style, and seemed more akin to a secure setting than an acute ward. The reviewers recognise that the ward has to be used for different functions because of being on an island, and significant efforts have been made recently to improve the inpatient environment.

The ward at the time of visiting had 6 staff (2 trained nurses and 4 Health Care Support Workers) on duty for 14 patients. This is a high staffing level given that it was reported that no patients where on a higher level of observation. Staff did report issues with staffing and high bank and agency usage at times. A new Nurse Lead for inpatient services was in post on an acting up basis which seemed positive.

The electronic prescribing and medicines administration system seemed effective.

There is a pharmacist attached to the wards in Orchard House, but this is limited.

The pharmacist resource could potentially be a very useful resource in helping oversee effective medicine management across the service, including monitoring and mitigating against polypharmacy.

There was dedicated Psychologist and Occupational Therapist input into the ward in line with good UK practise, although how this was co-ordinated was unclear.

A few issues were noted-

- Lack of a rapid tranquillisation policy (successfully addressed, see Addendum)
- The seclusion policy was out of date
- Some service users had polypharmacy prescribed. We are not suggesting that this was wrong but the process how this was reviewed and audited was unclear.
- One record we reviewed had no care plan from September.
- On one record we reviewed, the MDT meeting was not signed off by the consultant from 3 days ago.
- The Controlled Drug light outside the room was reported as not working, which is a legal requirement.
- Orchard House is a mixed sex facility. We did not see any guidance as to how this was managed, but it was reported that dignity was maintained.
- There was no policy for how admitted young people under 18 were managed on the ward, even though we were told that they always a 1 to 1 staff member with them, which causes its own problems for dignity and privacy.

We visited the older adults wards on the St Saviours site. As previously noted, the lack of a formal policy on anti-psychotic medicine in dementia was noted. There was a lack of Occupational Therapy, Physiotherapy, and dietician input into the wards. There was no process as to how emergency ECT might be delivered to patients when required.

Recent improvements at Orchard House include an improved focus on holistic recovery with the integration of support from psychology and occupational therapy, attempts to improve the patient experience despite the austere environment, and a focus on patient-centred care as a culture aspired to by all staff members. These are promising early improvements that should be supported now and in the new building.

IV. <u>CMHT</u>

The reviewers visited and spoke with staff across several disciplines as part of this review. We noted that the CMHT has a remit across the island and each member of staff has a pan-island role. Across the UK, it is normal practise for practitioners, including Consultant Psychiatrists, to work in dedicated catchment areas against a given population to allow them to work as a team and link into GP's and other community services.

The allocation of cases to the consultant psychiatrist seemed to be through allocation by the clinical lead, and it was unclear as to what criteria was used.
In line with the issues raised above, the issue of silo working was prevalent across the CMHT team.

The RCP quality guidelines for CMHT state –
Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others. Core 3.4 [1] 17 1
All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.
From our limited review of notes and with reference to serious incident investigations these aims are not regularly achieved. Whilst we saw excellent plans and letters for some patients, others did not have up to date treatment plans, and either no or conflicting diagnoses.
We could not see agreed standards for the recording of information in the notes.
The issue of professional silo working was noted. The lack of a formal CPA process and an agreed model of care significantly contributed to this. This has led to high levels of frustration between disciplines.

The service saw a lot of its patients at the CMHT base, which on one level is a potentially good use of resources, but in modern CMHT's clinicians always see a high percentage of people at home. We did not see how this was managed in the Jersey CMHT. The Jersey Care Model is in keeping with a modern model of care delivery that focusses on treatment as close to a patient's home as possible.
The overall model of Adult Mental Health Services in terms of how it fitted together in relation to the Jersey talking therapies, and the psychological assessments and therapy service was unclear, and was not written down anywhere. There did not appear to be any clearly articulated written care pathways.

V. <u>Communication</u>

Communication across the Adult Mental Health Service linked to many of the factors highlighted above. Staff did not feel involved or understood how decisions were made.
There seems limited involvement of patients (The reviewers were not able to fully confirm this with patients, as we were unable to meet any). The same could be said of relatives/carers. The Triangle of Care document, originally produced by the Carers Trust and widely adopted by Mental Health Trusts in England gives a clear process and standards for the involvement of patients, professionals, and carers. Feedback we obtained from carers suggests pockets of good care but a lot of confusion and frustration around structures and care delivery.

The reviewers were informed of a daily Adult Mental Health Service MDT huddle meeting which takes place each morning, although many staff reported that they were unsure of its purpose and its function.
Meeting minutes we reviewed were often difficult to follow, and it was highlighted that attendance at many meetings was sporadic across the service, which is shown in the minutes we reviewed.
There did not seem to be a briefing system in place for the Adult Mental Health service to convey information across the service.

VI. Clinical Issues - Medicine Management-

In relation to the medical workforce the reviewers met individually and collectively with most of the consultant psychiatrist group. It was noted there was a lot of positivity in relation to developing safe services, but there was also a lot frustration at the lack of consistent job planning and overall clinical leadership within the service.

There is a limited clinical audit process and a lot of the audits listed and seen by the reviewers were classed as ongoing/continuous without clear results. The clinical relevance of some audits was not obvious.

There were no audits relating to polypharmacy, which might have been useful. The role of the pharmacist in the audit process was underutilized.

The reviewers did feel that there was potential to use this group more effectively.

In the RCP paper on the role of the consultant psychiatrist the following is stated:

The seniority of a consultant psychiatrist within the multidisciplinary team can confer accountability for clinical leadership, but this is not automatic. The imperatives of leadership should include:

- clinical decision-making in multidisciplinary contexts
- managing dynamics in team settings
- professional development of colleagues
- service improvement and the drive for quality
- ensuring equity of access
- an ambassadorial role for health services, and an acceptance of wider roles outside the employing organisation
- horizon scanning, to anticipate developments in policy and practice, and then encourage evolution in service delivery

This further indicates the psychiatrist group are an underutilized group, disconnected from the CMHT, who lack clinical leadership and whose role as part of MDT working is not identified in the most effective way. The lack of an overall model of care and a CPA process are contributory factors.

VII. Other Adult Mental Health Services

Other services such as the CRHTT (Crisis Response Home Treatment Team) and the Liaison Service have the same problems in relation to team working, silo thinking, and clear management pathways as other services. The Liaison Service is in the process of renewing its formal accreditation with the Royal College scheme, which will help drive up standards against formal criteria. The drug and alcohol service seemed to work well but was not formally reviewed and it was felt that their staff were sometimes taken to cover gaps elsewhere.

VIII. Information and data

As part of the review, we asked for information on the percentage of people who receive regular supervision and the percentage compliance with mandatory training. This proved very difficult to get for both the overall Mental Health Service and individual teams, some teams collated this information, and some did not.

The information supplied regarding compliance with action plans was often confusing with issues noted as *red* (not on target), and with comments such as *in progress*. When this was further inspected by the reviewers, a lot of these issues were not progressing and stuck, CPA or equivalent being an example of this.

The caseload management systems for the CMHT were unclear and, because of the lack of MDT working, were uncoordinated. The current data recording system makes it difficult to find summary information on patients.

10. Major findings of the Review

The major findings of this review are based against the 5 key lines of enquiry used by the care quality commission in England. These are Safe, Effective, Caring, Responsive and Well-led.

The reviewers found no evidence that staff were uncaring. We found caring and motivated clinicians, but staff who were often frustrated by the lack of leadership within Adult Mental Health and clarity of strategy.

- Senior Leadership of Jersey Mental Health Services (Well-led and Safe)

There is a clear lack of strategic direction within the Adult Mental Health Service, together with a lack of system and processes needed to make the service safe, give the service good governance, and to aid high quality care. This has led to silo working across professions and teams. There is a lack of a clear model for the service in line with the Jersey Model of Care.

The service overall is not safe. Not being safe does not mean that every patient treated in

the service received or receives an unsafe service. Instead, it means that the service has a high risk of serious incidents. Any remedial action in accordance with the recommendations and good practice, taken by the Executive Team will reduce this risk.

Recommendation 1,3 and 4

Pockets of good practice exist. This includes for example the Drug and Alcohol Service, the improvement process the Psychiatric Liaison Service is undergoing, the improvement process in Orchard House, and the dedication of many staff we encountered.

- Lack of CPA or equivalent (Safe, Effective, Responsive and Well Led)

The fact that the services lack an implemented system of MDT working is a major risk factor and likely to be a factor in further incidents.
It is of concern that this has been highlighted in several previous serious incident reviews, but has not been acted upon.

This is a major risk factor. Future serious incidents remain likely, but have already reduced somewhat due to the immediate actions taken by the Executive Team. For details of actions already undertaken to mitigate these risks please see the Addendum.

Recommendation 2

- Policy and Procedures (Effective Safe Responsive and Well - Led)

The report has highlighted the absence of several key policies and identified a clear lack of a process for policies to be ratified, leading to many key policies not having been completed, or permanently in progress.

This is a clear risk factor and a major safety concern. Any remedial action in accordance with the recommendations and good practice will reduce these safety concerns and the risk to patients (see Addendum).

Recommendation 1,5 and 10

- Governance systems (Well-Led, Safe, Effective and Responsive).

This review has highlighted within Adult Mental Health the lack of overall systems and processes for governance, which is a major concern for the service. There is also a lack of role clarity for several staff and an overall lack of supervision and objectives, both for services and individuals.

Coupled with this is the issue of silo working by professional group and by individual teams. This leads to an ineffective use of resources. There is a lack of learning from serious incidents across the service, and a limited process to ensure any recommendations are actioned. The lack of a clear management processes has led to individual managers making decisions in isolation and high levels of frustration in the service.

This a further high-risk area. Any remedial action in accordance with the recommendations and good practice will reduce these safety concerns and the risk to patients (see Addendum).

There is an ineffective use of resources.

Recommendation. 1,4,5 and 10

- Adult Mental Health Inpatient areas (Safe, Well-led, Responsive, Effective)

Issues with the Adult Mental Health inpatient wards have been highlighted in previous reports. Progress is being made and a new site is being developed. A new nurse lead is in place.

However, the issues pertaining to MDT working remain pertinent in this area and this affects discharge processes in particular.

The lack of some individual policies and processes where highlighted in this report and are a major risk.

And it was noted that Orchard House as the only adult mental health ward on the island can be multi-functional.

, and the austere nature of the physical environment of Orchard House was noted.

Recommendation 8,9, and 10

- CMHT (Well-led, Safe, Responsive, Effective)

The issue of a lack of a CPA system or equivalent is particularly pertinent here. The silo way of working was very apparent with reference in particular to the role of medical staff.

The CMHT did not work to a usual sector/catchment area configuration, which is normal in most other services.

Recommendation 4,2,5,7,9 and 10

- Medicines Management (Safe, Well-led, Effective)

As highlighted, there was a lack of key medicine policies within the Adult Mental Health Service, for example, Clozapine, rapid tranquilisation, and anti-psychotics in dementia.

There is limited pharmacist input into the service.

There seemed a lack of process to review poly-pharmacy issues in line with best practise.

There seemed a lack of ongoing audit in relation to nice guidance and medication.

Recommendation 5,8,7,9

- Overall Management Capacity (Well-led, Effective, Responsive)

The report has highlighted the lack of and this led, together with the lack of system process and supervision with clear objectives, to managers working in silos and making decisions in isolation. Consequences of these decisions were not always considered, and decisions often lacked proper consultation.

There are several management support posts, whose functions need to be clarified.

Although managers spoke of being very busy, the reviewers felt there was enough capacity in the system. It needs to be managed better.

Recommendation. 1,4,5 and 10

- Information

As indicated, there is a lack of meaningful data collected by the service, and that which is collected is not used in a meaningful way to ensure safety and to develop services.

Recommendation 10,7,4,9 and 1

11. Conclusion

This conclusion is looked at against the key objectives the reviewers were given:

> Examine the models and pathways of care delivery within the service and assess whether they are delivered in line with current legislation, standards, and evidence-based guidance to achieve effective and appropriate safe care and outcomes.
>
> **The review has found that the different parts of the Adult Mental Health Service are not linked effectively, and suffers from silo thinking and lacks a formal operating system such as the Care Programme Approach. Many parts of the service**

are not delivered in line with current standards and evidence-based guidance. There is a lack of efficiency and safety in many parts of the service.

Appraise how well people who use services and their family's needs are assessed and if care and treatment is delivered in line with current legislation, standards, and evidence-based guidance to achieve effective outcomes.

Compounded by the lack of a CPA system, there are not formal systems to ensure the routine safe delivery of care to patients, their families and carer. This is not to say it does not happen, but that it is not consistently done against an agreed standard in a co-ordinated manner.

Judge systems in place to improve physical outcomes for people who use services in line with 'whole person care', to achieve parity between mental and physical health; including the ability of services to recognise and respond to physical deterioration and joint working between mental health, acute and community physicians.

This was difficult to review effectively due to time constraints and the number of people the reviewers needed to see. However, the reviewers did not see clear pathways between the in-patient unit and the general hospital. Liaison Services into the main hospital suffer from a lack of resources, office space and poor assessment facilities in ED.

Evaluate the management structures, model of leadership and the capacity and capability of the service in terms of human resources (including MDT and support functions) and consider whether the current systems of accountability are effective and support high quality, safe and sustainable services.

The review has highlighted issues with the senior leadership within the Adult Mental Health Services and how this affects management throughout the Adult Mental Health Service. The MDT working lacks a formal process to bind it together and there are issues with silo thinking at a team and at a professional level. There is a complete lack of coherent accountability. This leads to false assurances to the HCS Executive Team.

Assess the culture within the service and whether this enables openness and honesty at all levels, including with people who use services, in response to incidents; considering if the relationships amongst staff teams enable them to work collaboratively, share responsibility and resolve conflict quickly and constructively

This review has found ongoing issues with the learning from serious incidents in that actions are not completed in a timely or effective manner. The process of learning from incidents is not cascaded across the service. In some cases, there are no action plans to completed reviews.

The reviewers found there was often a poor culture amongst Adult Mental Health teams with a high level of friction and animosity. These are further exacerbated by a lack of co-ordinated management across these teams.

Examine the overall safety of the service and assess the processes for managing risks, issues and performance and monitoring safety, learning and continuous improvement.

Due to a lack of a formal system of MDT working in Adult Mental Health, a lack of learning from serious incidents, and the poor management processes especially around agreeing and implementing policies and procedures, there is a high likelihood of further incidents. Any remedial action in accordance with the recommendations and good practice will reduce these risk to patients (see Addendum).

There is a lack of a formal clinical risk policy covering all disciplines. We do not consider the services to be consistently safe. Any remedial action in accordance with the recommendations and good practice will reduce these risk to patients (see Addendum).

Judge what a modern Adult Mental Health service should look like for an island such as Jersey, aligned to local plans in the wider health and social care economy, particularly in terms of workforce and especially for the medical workforce, taking into consideration the needs of the planned and unplanned aspects of the service.

The review has highlighted that

- **Adult Mental Health Services lack clarity of purpose and a defined model of care. Defining a model of care in line with UK best practice and the Jersey Care Model should lead to improved management structures and the development of measurable outcomes.**
- **CMHT would be better if services worked to agreed catchments areas on the island, and that the overall model of care needs to be described as a single system and not as its individual components. The lack of CPA or an equivalent further fragments services.**
- **The model of care for acute in-patients needs to be developed in line with best practise.**
- **The role of private practice in Adult Mental Health should be examined. It was reported that private healthcare may potentially restrict access for this vulnerable patient group. There are also potential conflicts of interest when prescribing medical cannabis and ADHD medication in private settings.**
- **Nursing and medical professionals in Adult Mental Health will need to work better together to achieve high levels of MDT working. The Royal College of Psychiatrists' guidelines for consultant psychiatrists mentioned above can be a good guiding principle for the development of effective MDT working.**
- **The development of effective independent nurse prescribing can aid greatly to free up consultant time in an environment where shared care agreements with primary care do not exist, thus placing a high burden on consultants to prescribe. We have been told that the framework, governance and legislation for this is in place and Mental Health Services should consider its further utilization in relation to their service model of delivery and workforce plan.**

Highlight areas which positively contribute to the service which should be supported and maintained through any changes.

The reviewers met a lot of dedicated staff working in Adult Mental Health across all disciplines who had a genuine desire to improve services and provide excellent care. There was a lot of positive staff we saw from the liaison service who understood best practise. This needs to be supported and encouraged.

We noted best practice of the HCS in their approach in inviting an external review in order to understand how best to improve services for patients and staff.

Identify how an island such as Jersey could link into a network to help enhance and support the quality and safety of the on-island services.

The review has highlighted the Royal College of Psychiatrists accreditation scheme across a number of services which would provide useful standards, networks, and accreditation. The service could also potentially look at having some critical friends to provide advice and support as it develops.

Addendum:

Since the review, the Executive Team told us that the following pieces of work have been finished or are in progress:

- Clozapine Policy. Done by Dr Paul Hughes, Deputy Medical Director
- Rapid Tranquillization Policy. In progress, done by Dr Paul Hughes, Deputy Medical Director
- Protocol for antipsychotic medication in dementia. In progress, done by Paul Hughes Deputy Medical Director

The Executive Team told us that the following measures have been initiated since the review:

- The HCS has stood down and put in a team with executive powers.
- The HCS has halted the integration of Adult Mental Health and Adult Social Care. They have put in place executive oversight and governance ie, a weekly meeting with the interim leadership for Adult Mental Health Services and the Executive of HCS, chaired by the Director General.
- All of these actions have been implemented with immediate effect and all recommendations have been accepted in full.

Comment from reviewers: Taking these actions will have an immediate impact on reducing risk and improving safety.