

# VERITA

IMPROVEMENT THROUGH INVESTIGATION

**Independent investigation into the care and treatment of**

**Ms C**

A report for  
NHS England, North Region

November 2014

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# **1 Introduction**

NHS England, North Regional Team commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Ms C.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation might not identify root causes or find aspects of the provision of healthcare that directly caused an incident but it will often find things that could have been done better.

The Chief Executive of Mersey Care NHS Trust commissioned an internal Trust investigation into the care and treatment of Ms C.

The internal investigation team made seven recommendations and an action plan was developed to implement them.

## **1.1 Background to the independent investigation**

On 22 March 2012 Ms C, a 38-year old-woman, was arrested by the police and charged with the murder of her ex-partner on 27 February 2012. She was found guilty and sentenced to serve at least twenty three years in prison.

Ms C was receiving care and treatment from Mersey Care NHS Trust at the time of the incident.

## **1.2 Overview of the Trust**

Mersey Care NHS Trust provides specialist inpatient and community mental health, learning disability and substance misuse services for adults in Liverpool, Sefton and Kirkby.

It has a wider role in providing medium secure services for Merseyside and Cheshire, and high secure services covering the North West of England, the West Midlands and Wales.

## 2 Terms of reference

The terms of reference for the independent investigation, set by NHS England, North Regional Team in consultation with Mersey Care NHS Trust are as set out below.

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of the offence.
- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with victim support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the investigation team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post-investigation evaluation.

### **3 Approach of the independent investigation**

The investigation team (referred to in this report as 'we') comprised Liz Howes, a Verita associate, and Chris Brougham, a senior investigator from Verita. Professional psychiatry advice was provided by Dr Peter Jefferys, honorary consultant psychiatrist, Norfolk & Suffolk NHS Foundation Trust. Biographies of the team are given in appendix A.

We examined a range of Trust documents, including policies and procedures, the Trust internal investigation report, and supplementary information, such as the Trust investigation action plan and records of meetings with staff.

Ms C gave her written consent for us to access her medical and other records for the purposes of the investigation.

We met Ms C at the outset of the investigation to explain the nature of our work and to inform her that the commissioners of the investigation would probably publish the report in some form. Ms C was given the opportunity to comment on a draft of this report before it was finalised.

We also met with Ms C's parents at the start of our work to explain about the investigation and to see whether they had any views about Ms C's treatment and care. We contacted them again at the end of the investigation to share with them what we had found in our investigation.

We also offered to meet with the victim's family, but they declined. We respect their decision. We wrote to them again at the end of the investigation to ask if they would like us to share the findings of the investigation with them.

We interviewed Trust staff only where we found a gap in information or an area that required clarification, or to find out what developments had taken place since this incident.

We interviewed the following staff:

- a consultant psychiatrist from the Community Mental Health Team (CMHT);  
and
- Director for Patient Safety.

We based our findings on analysis of the evidence we received. Our recommendations are intended to improve services.

This report includes a chronology outlining the care and treatment of Ms C. The analysis appears in sections 7 to 13 where relevant issues and themes arising from the terms of reference are examined.

Derek Mechen, a partner at Verita, provided peer review for this report.

## **4 Executive summary and recommendations**

NHS England, North Regional Team commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Ms C.

The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation might not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it might find things that could have been done better.

### **4.1 The incident**

On 22 March 2012 Ms C, a 38-year-old woman, was arrested by police and charged with the murder of her ex-partner on 27 February 2012. Ms C had been in a relationship with the victim for 13 years until approximately 6 months prior to the incident. They have two children.

Ms C was receiving care and treatment from Mersey Care NHS Trust at the time of the incident. She was found guilty of murder, and sentenced to serve at least 23 years in prison.

### **4.2 Overview of care and treatment**

On 22 August 2011, Ms C was referred by her GP to Mersey Care Crisis Resolution Home Treatment (CRHT) access team. She was assessed on 9 September 2011. She presented as being distressed with jealousy and paranoid beliefs towards her partner. She was referred for short-term crisis intervention<sup>1</sup>.

Ms C was seen nine times by CRHT during the period August to October. She also attended an outpatient appointment in September. After a medical review in October she was discharged from CRHT and transferred to outpatients at the Community Mental Health Team (CMHT).

There is no evidence that a formal handover of her care took place between CRHT and the CMHT. We found no evidence that this made any difference to the care that was provided to Ms C. This has already been identified as an issue in the Trust internal investigation.

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<sup>1</sup> Short-term crisis intervention is intensive involvement by professionals to provide the patient with coping strategies.

She was seen in November by a psychiatrist from the CMHT at an outpatient appointment. The psychiatrist advised Ms C that arrangements would be made for her to receive supportive counselling at Inclusion Matters<sup>1</sup> and wrote to the GP on 4 November 2011 to request a referral.

However, we found no further evidence or information in the notes to show that Ms C had actually been referred to Inclusion Matters. When we met with Ms C's father, he told us that she had attended counselling, but was unable to say where this had been provided, and he felt she had improved since attending. We also asked Ms C where she had received the counselling but she was unable to tell us.

### **4.3 Overall conclusions of the independent investigation**

Ms C had no history of violence. It has not been possible to identify any aspects of Ms C's treatment or management between September and November 2011 that would have prevented the incident in February 2012 from happening.

Nevertheless, we did find that some aspects of Ms C's care could have been better. The Trust failed to provide follow-up for her after 2 November 2011. Had she continued to be monitored, her treatment may possibly have been altered in response to changes in her mental state or level of risk. However, without any evidence about Ms C's mental state after 2 November we do not know if the incident could have been predicted if follow-up had occurred.

The lack of follow-up after 2 November was a missed opportunity, and as a result of it staff did not have the knowledge or means to prevent the incident.

Ms C was appropriately offered high-frequency input from CRHT in the weeks following her initial assessment. This included liaison with the health visitor, a psychiatric review and continuation of antidepressants. She also received advice about support mechanisms.

This approach was an appropriate response to Ms C, who presented with a first episode of moderate depressive illness.

Having reviewed the recorded clinical information, we found that Ms C's jealousy of her partner and her paranoid beliefs were direct consequences of her depressive illness. There is evidence in the notes that these beliefs had dissipated by 2 November 2011 following effective treatment.

We also found that it was appropriate for Ms C to be discharged from CRHT and transferred to outpatient appointments with a psychiatrist as her condition improved. However, we could find no evidence of a formal handover of care, but we found no evidence that this made any difference to the care that was provided to Ms C. This has already been identified as an issue in the Trust internal investigation.

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<sup>1</sup> Inclusion Matters Liverpool is an NHS Service providing a range of talking therapies for common mental health problems from GP practices and other locations across Liverpool.

The single major failing, which was also identified in the Trust's internal investigation, was the failure to arrange outpatient or any other follow-up after Ms C was seen on 2 November 2011. This was a serious systemic service failure as her mental state and level of risk were no longer being monitored.

Since this incident, the Trust has implemented the necessary actions identified in the internal investigation. It has integrated the CRHT and the Assertive Outreach Teams (AOT) into the Community Mental Health Teams. We heard at interview that this has improved the continuity of care for service users.

A pilot for risk assessment training is currently being tested; if successful, it will be introduced throughout the Trust. A redesign of the risk assessment process to be more formulation-focused<sup>1</sup> has also been implemented providing a clear link between risk assessment and the most suitable management plan.

A revised system for repeat regular outpatient appointments has also been implemented, but we have made a recommendation as a result of our interviews with staff to promote a consistent approach for ad hoc appointments.

We have also made a recommendation that the Trust should provide assurance that the changes they are making are delivering the required service improvements.

#### **4.4 Recommendations**

The Trust should assure itself that there is a robust and consistent process in place to ensure ad hoc outpatient appointments are made.

The Trust should provide assurance that the reorganisation of services and the systematic changes being made deliver the required service improvements with a specific focus on handover of care, risk assessment, risk management and Care Programme Approach (CPA).

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<sup>1</sup> A clinical formulation is developed from the information obtained through clinical assessment. Formulations are used to provide the most suitable treatment approach.

## 5 Chronology of care and treatment

Ms C was born and brought up in Liverpool. She is the eldest of three sisters. After leaving school, she trained and worked as a hairdresser. She also trained to be a healthcare assistant.

At the time of the incident, Ms C had been in a relationship for thirteen years with her partner (the victim). They have two children.

### 5.1 Contact with Trust

On 19 August 2011, Ms C was referred by her GP to mental health services with symptoms of severe to moderate depression.

On 9 September 2011, a practitioner from the CRHT access team at Mersey Care NHS Trust assessed Ms C. She presented as being distressed so was referred for short-term crisis intervention. A risk assessment and care plan was completed.

The management plan was as follows:

- Ms C was to have a full blood screen, including hormone levels, to rule out such conditions as hyperthyroidism<sup>1</sup>;
- a full assessment statement was to be sent to Ms C's GP, who would be asked to approve an increase in her dose of mirtazapine<sup>2</sup> to 30mg; and
- Ms C was to commence on full Care Programme Approach (CPA).

Ms C was seen again at home on 13 September by a CRHT support worker. Ms C was very tearful but had no thoughts of deliberate self-harm. She said she would contact CRHT if she needed further support.

Ms C was discussed in the multidisciplinary team review meeting on 14 September and an appointment was made for her to see a psychiatrist working in CRHT and a CRHT worker on 20 September.

On 15 September, Ms C was seen again, at home, by a CRHT support worker. Ms C reported that she had had a good day.

On 17 September 2011, a CRHT practitioner visited Ms C at home. She presented as being tearful and distressed. The records show that Ms C's mood changed approximately four years ago when she became extremely 'obsessed' with her partner checking up on his every move and jealous. It is also recorded that the more recent trigger to her low mood is when he finished their relationship a couple of weeks ago and left the home for four days. The records also show that Ms C said to staff that 'she was constantly, deliberately arguing, bickering with her partner and was worried all the time'. She also said that 'she was constantly crying and was

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<sup>1</sup> Hyperthyroidism means a raised level of thyroid hormone.

<sup>2</sup> Mirtazapine is a noradrenergic and specific serotonergic antidepressant.

distressed in front of her children'. The records also show that Ms C admitted to smoking skunk (a form of cannabis) every day. Her medication was noted as being mirtazapine 30mg. A joint visit by her health visitor and the CRHT team was discussed. A further visit from the CRHT team was also planned.

On 18 September a CRHT practitioner visited Ms C, who was at her mother's house. It is recorded in the notes that Ms C was assessed and was "bright in mood" and it was evident that she had cleaned the house.

On 19 September CRHT contacted the health visitor (HV) to arrange for additional support for Ms C. A joint visit was arranged for 22 September.

CRHT also informed the Trust's safeguarding team of its involvement with Ms C.

On 21 September 2011 a CRHT psychiatrist and a CRHT practitioner reviewed Ms C at an outpatient clinic. Records show that Ms C was very tearful during the review. She told staff that her relationship with her partner had been very difficult recently and that he was leaving her. Ms C described a history of low mood since the birth of her youngest child, and said that she had not suffered low mood prior to the birth.

The management plan was that:

- there was to be a joint visit by CRHT and health visitor; and
- Ms C was to continue on her current medication (mirtazapine 30mg).

On 22 September a CRHT practitioner and the health visitor assessed Ms C at home. Ms C's mother and children were at the house and were included in parts of the meeting. Ms C reported to the practitioner that she felt better and was taking her medication. She also said that she had had difficulty in getting out over the three years since the birth of her youngest child. The records show that staff had no concerns over the children and their safety. The next visit was planned for 24 September.

On 24 September a CRHT support worker passed Ms C in her car as she was approaching Ms C's house. Ms C pulled over and said she had forgotten the appointment. The support worker recorded in the notes that Ms C was "well kempt and facially bright". She was on her way to meet her family for a meal. She said she would contact the team if she needed any further support.

A CRHT support worker visited Ms C again on 26 September and Ms C said she was "feeling a lot better". Her sleep and appetite had improved and she was taking her medication. She reported that she was going on holiday to Greece on 9 October. The next visit was planned for 28 September.

The CRHT support worker carried out a further visit on 28 September. Ms C showed no signs of anxiety and said she was looking forward to her holiday.

A CRHT practitioner visited Ms C again at home on 30 September. Ms C remained well and declined a visit over the weekend. The CRHT worker reminded Ms C of her appointment with a psychiatrist on 4 October.

On 4 October 2011 the CRHT staff grade psychiatrist undertook a medical review. Ms C said she felt much better. She was relieved that her partner had left her, because they were arguing all the time. Ms C stated that she still had problems sleeping as her mind would start to race when she went to bed. Ms C stated that her mood had been quite positive and that she had stopped smoking skunk over a week before. Her diagnosis was recorded in the notes as being a moderate depressive episode (currently in partial remission) and that her medication was mirtazapine 30mg daily.

The management plan for Ms C was as follows:

- to discharge her from CRHT to CMHT outpatient department for short-term input;
- to continue her prescribed medication;
- to contact health visitor about additional support;
- to consider Sure Start (local government support services for children and their families); and
- to consider Women's Health Information and Support Centre (WHISC).

Records show that on 4 October a secretary emailed the CMHT consultant requesting a transfer of care *for "outpatient appointments only"*.

The notes show that on 27 October a CMHT psychiatrist was identified to review Ms C on an ongoing basis in the outpatient clinic.

On 2 November 2011 a specialist registrar in psychiatry assessed Ms C in the outpatient clinic. In a letter to the GP, the psychiatrist explained that Ms C had been receiving care from CRHT, but had been discharged from their care some four weeks previously. Ms C reported that for the past two weeks she had not been feeling good, her sleep had been disturbed and she had stopped driving as her concentration was not good. Ms C had been going through a separation from her partner, who had now moved out. The notes show that Ms C's difficulties first started after the birth of her youngest child. Ms C was assessed as being a low risk of suicide and a low risk of harming her children. Ms C told the psychiatrist that she no longer believed or suspected her partner had been in another relationship and that it was mainly her suspicions.

The management plan was as follows:

- mirtazapine 45mg at night;
- zopiclone<sup>1</sup> 3.75mg initially at night pro re nata short term for insomnia, to increase to 7.5mg if necessary;
- arrange supportive counselling at Inclusion Matters via GP;
- risk of suicide low. risk to children low;
- health visitor to be advised of engagement with mental health services; and
- to be reviewed in clinic in three weeks.

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<sup>1</sup> Zopiclone is a non-benzodiazepine used in the treatment of insomnia.

There is no evidence that a further appointment was made and no record of any further contact with Ms C.

On 22 March the criminal justice liaison team was asked to review Ms C as she had been arrested, with four other people, on suspicion of the murder of a male in his own home, following a group of people entering the property on 27 February 2012.

The victim was reported as being the ex-partner of Ms C.

Ms C was charged with the involvement of murdering her ex-partner to which she pleaded not guilty. She was found guilty of murder on 10 January 2013 and sentenced to serve at least 23 years in prison.

## **6 Issues arising**

In the following sections of the report we analyse and comment on the issues in relation to the care and treatment of Mr C that we have identified as part of our investigation.

We considered the following issues:

- the formulation of diagnosis and pathway of care;
- the care programme approach and care management;
- risk assessment and risk management;
- safeguarding;
- predictability and preventability;
- the Trust's internal investigation; and
- progress on implementing action plan.

## 7 Formulation of diagnosis and pathway of care

In this section we examine whether due consideration was given to Ms C's diagnosis and whether she was on the right pathway of care.

### 7.1 Diagnosis

The initial GP referral in August 2011 provided valuable information about Ms C's presenting symptoms. These were:

"Low mood, started after had baby two years ago, symptoms gradually worse now is bursting into tears all the time getting increasingly aggressive with family members. Hardly getting any sleep. Becoming increasingly paranoid. Comfort eating. Anhedonia<sup>1</sup>. Feels tense all the time, can't relax. No suicidal ideation. Doesn't go out anywhere".

The GP referral included a risk assessment. This highlighted the following factors:

"Expressing high levels of distress; helplessness OR hopelessness; lack of positive social contacts; unable to do major shop alone; paranoid delusions about others".

The diagnosis suggested was "moderate to severe depression", possibly related to an unresolved postnatal depression. Treatment with an antidepressant had been started.

During Ms C's initial assessment undertaken by CRHT on 9 September 2011, similar features were recorded. Her partner was recorded as the recipient of her paranoia:

"Partner has now had to leave the house because she is continually paranoid and argumentative with him".

A fuller assessment was arranged for two days later on 11 September at her home when her mother was also seen briefly. Ms C was noted to be experiencing a range of anxiety and depressive symptoms. She was also "subjectively and objectively low, tearful and tense", although she "denied any psychotic phenomena".

In addition, "she denied any thoughts of suicide or deliberate self-harm or harm to others. She reported racing thoughts and paranoid thoughts about people talking about her. She continues to have thoughts about her partner having an affair but blames herself regarding the breakdown of the relationship".

We found no diagnostic formulation was recorded although Ms C's care plan and clinical management that followed were consistent with a diagnosis of depressive illness of moderate/severe intensity with fluctuating severe anxiety. Antidepressant medication was continued and frequent home visits were arranged. These continued until early October 2011.

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<sup>1</sup> Anhedonia is the inability to gain pleasure from enjoyable experiences.

The notes of a visit on 17 September 2011 record that Ms C's mood changed approximately four years ago when she became extremely 'obsessed' with her partner checking up on his every move and jealous. It is also recorded that "the more recent trigger to her low mood is when he finished their relationship a couple of weeks ago and left the home for four days". For the first time a record was made of Ms C smoking "skunk every evening a little".

Ms C was seen for the first time by a psychiatrist on 20 September 2011. Records show that she was tearful and said she had been low in mood since her youngest child's birth. She had also "become preoccupied with what her partner was doing and if he was cheating on her – never having been like this in the past". Increased support and continuation of antidepressant medication were recommended. Ms C's GP was informed. There is no evidence that Ms C's diagnosis had changed.

At psychiatric follow-up on 4 October 2011 it is recorded that Ms C's was "greatly improved" and her mood "appeared positive". She "denied any unusual beliefs" and "stated she no longer is preoccupied with what her ex-partner is doing". She was discharged to routine outpatient follow-up with a diagnosis of "moderate depressive illness (currently in partial remission)".

Ms C was reviewed as an outpatient four weeks later on 2 November 2011. She reported some recent disturbance of sleep but was not psychotic and was otherwise coping. A modest increase in antidepressant dosage was recommended by the psychiatrist who saw her. A full letter was sent to her GP on 4 November 2011 which referenced her earlier mistrust of her partner:

"A couple of weeks after she gave birth she said she was feeling suspicious about her partner and was worried whether he was entering into another relationship. She said that this went on for the last two to three years and now they have separated. Ms C says that she does not now suspect that her partner was in another relationship and it was mainly her suspicions. She did not report any violence in the relationship and did not report any aggressive thoughts toward him".

At this appointment the plan was for Ms C to access talking therapies via the GP and a request for this to happen was included in a letter to the GP dated 4 November. We could find no evidence in the notes that a referral was made, but Ms C's father told us at interview that she appeared to improve after she started the counselling and things were going well. He did not know if the counselling was provided by Inclusion Matters. We also asked Ms C where she had received the counselling but she was unable to tell us.

#### 7.1.1 Analysis

Ms C's GP provided sufficient evidence in the referral letter to support a probable diagnosis of depressive illness of moderate severity. This GP diagnosis was in effect endorsed subsequently by the mental health service. A range of symptoms of fluctuating intensity was identified consistent with a diagnosis of depressive disorder of moderate severity.

This was the appropriate diagnosis of the mental disorder experienced by Ms C in 2011.

Ms C's GP made reference to her paranoid and jealous beliefs regarding her partner. These were subsequently explored to some extent by mental health staff, and discussed in letters to her GP written by the psychiatrists who saw her. Their presence and lengthy duration were confirmed by her partner. The timing of Ms C's beliefs about her partner's fidelity was linked to the onset of her depressive illness around the time of her youngest child's birth. They persisted alongside her depression. When last assessed in November 2011, Ms C was free of any paranoid beliefs concerning her partner and showed insight into her earlier abnormal beliefs.

Both intermittent and persistent jealousy are common in the general population. There is no indication that Ms C exhibited pathological jealousy prior to her last pregnancy. Her jealousy was linked to the development and persistence of her depressive illness following her youngest child's birth. People with moderate depressive illness commonly experience loss of self-esteem and feelings of sexual inadequacy and in some cases develop a belief that their partner finds others more sexually attractive. It may take very little for such a belief to reach delusional intensity.

Having reviewed the recorded clinical information, we found that Ms C's jealousy and paranoid beliefs towards her partner were direct consequences of her depressive illness. There is evidence in the notes that they had cleared by 2 November 2011 following effective treatment.

Although we found that the service's diagnostic formulation was inadequate insofar as it did not include any discussion of the significance of Ms C's jealousy, even if it had done so, the primary diagnosis of moderate depressive episode would have remained unchanged. The core task for the mental health service monitoring Ms C's functioning with particular attention to depressive symptoms and compliance with antidepressant medication would have been unchanged.

### 7.1.2 Conclusion

The diagnostic formulation was inadequate as it did not include any discussion of the significance of Ms C's jealousy. Even if Ms C's jealousy had been taken into account, the primary diagnosis of moderate depressive episode would have remained unchanged. The Trust has undertaken work on ensuring that jealousy and suspicion in relationships is included in risk assessment training and documentation we have therefore made no further recommendation.

## 7.2 Pathway of care

On 9 August 2011 Ms C was assessed by a practitioner from the CRHT access team at Mersey Care NHS Trust. She presented as being distressed, so was referred for short-term crisis intervention.

She was seen nine times by eight different members of the CRHT team and again at an outpatient appointment in September. After a medical review in October she was discharged from CRHT and was seen in outpatients by the CMHT psychiatrist.

On 19 September 2011 Ms C told staff that she smoked skunk every evening “only a little” and when seen on 4 October she told the psychiatrist that she had stopped smoking it. She was seen frequently over an eight-week period but none of the mental health professionals raised concerns about a link between her mental state and her use of cannabis. Neither her partner nor mother mentioned cannabis or alcohol misuse. Her health visitor raised no concerns about drug misuse. There was no indication that Ms C abused alcohol; nor was she referred to drug and alcohol services.

On 2 November at an outpatient appointment the psychiatrist and Ms C agreed that arrangements would be made through her GP for supportive counselling at Inclusion Matters.

Ms C should have been seen again in outpatients three weeks later, but there is no evidence that this appointment was made. Ms C was not seen again by mental health services.

### 7.2.1 Analysis

Offering regular support from the CRHT team in the weeks following the initial assessment was an appropriate response to Ms C who had a first episode of moderate depressive illness.

Ms C was seen by a number of different members of the team but there is no evidence this had a negative effect on either Ms C’s short or long-term outcome as the care and treatment she received were well documented and coordinated. Crisis Resolution Teams adopt a team based approach that allows greater flexibility to meet the fluctuating and intensive demands of the team cases.

It was appropriate for Ms C to be transferred to the CMHT team for outpatient appointments as her condition improved. However, there is no evidence that a formal handover of care took place between the CRHT team and the CMHT but we found no evidence that this made any difference to the care that was provided to Ms C.

Given that Ms C had depression and not psychosis, there was no indication for a referral to drug and substance misuse services.

There was a failure to arrange outpatient or any other follow-up after Ms C was seen on 2 November 2011. This was a serious systemic service failure and one that was highlighted in the Trust investigation report.

We found no evidence or information in the notes about Ms C’s referral to Inclusion Matters, but Ms C’s father told us that he felt she improved after the counselling started. He did not say if the counselling was provided by Inclusion Matters. When we interviewed staff we were told that access to the service has changed and can

now be arranged directly without going through the GP and that this has improved the process.

### 7.2.2 Trust developments

Since this incident, the Trust has restructured the community services. The integration of the CRHT and the AOT into the Community Mental Health Teams has improved the handover processes between them and the practitioners who were involved with Ms C. The community services have developed a stepped-up care approach for service users who have a crisis, with the care coordinator remaining as the main contact person during the service users' care. Staff told us at interview that the integration of CRHT with the CMHT has improved the continuity of care for service users. We have made a recommendation that the Trust should provide assurance that these changes have made the required service improvements.

The Trust has also told us that the system for issuing repeat outpatient appointments has been revised as follows:

“The pending booking system was rolled out to all adult services across the Trust. The system involves the service user attending clinic and being advised verbally by the psychiatrist as to when their next appointment will be, for example, in three or six months' time. The service user passes this information onto the clinic receptionist on their way out, whereupon the receptionist advises them that a letter will be sent out by post 4–6 weeks prior to their next appointment date. Upon receiving this letter, the service user will be able to choose and confirm their appointment by phone. This is in contrast to the previous, fixed system, whereby the service user would be given their next appointment date on a card there and then at the clinic.

“A reminder service has also been implemented when service users are reminded of their outpatient appointment by letter one week before the appointment followed up by a telephone call the day before the appointment. Patients who have given consent to receive automatic appointment reminders as part of the Automated Reminder System (ARS) Process will receive an automatic SMS or voice reminder one week and then one day before their appointment date”.

However, in interview, staff told us that the above process refers to regular clinic appointments. The nature of the work is that medical staff, particularly SpRs,<sup>1</sup> sometimes have to see people more quickly, outside of clinic, and these appointments are not in a regular clinic system. This means that there is not an automated system to ensure that reminders and prompts are sent. The team that cared for Ms C has a local system, but this may not be consistent across all services within the Trust.

We have therefore made a recommendation aimed at ensuring that robust systems are in place to cover all appointments however they are generated.

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<sup>1</sup> A Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order to become a consultant.

### 7.2.3 Conclusion

The failure to arrange an outpatient appointment after 2 November 2011 was a serious systemic failure. This was a missed opportunity to monitor Ms C's mental state.

### 7.3 Recommendation

The Trust should assure itself that there is a robust and consistent process in place to ensure that ad hoc outpatient appointments are made.

## 8 The Care Programme Approach and care management

In this section we examine how the CPA was used to plan Ms C's care.

CPA is the process that mental health services use to coordinate the care of people with mental health problems. The concept was introduced in 1991, and in 1999 *Effective care coordination in mental health services – modernising the care programme approach* set out the arrangements for all adults of working age under the care of secondary mental health services. The key elements of CPA are:

- systematic arrangements for assessing the health and social care needs of people accepted by specialist mental health services;
- a care plan which identifies the health and social care to be provided from a range of sources;
- a named care coordinator to keep in touch with the service user and to monitor and coordinate care; and
- regular reviews and agreed necessary changes to care plan.

The Department of Health published *Refocusing the care programme approach* in March 2008. This document updates the guidance and emphasises the need to focus on delivering person-centred mental health care. It also confirms that crisis, contingency and risk management are integral parts of assessment and care planning.

The Trust *Corporate policy and procedure for the care programme approach* dated March 2011 includes key elements of national policy and best practice. The policy also deals with issues around implementation, review, monitoring and audit. In the introduction the document explains:

- why the policy is necessary;
- to whom it applies and where and when it should be applied;
- the underlying beliefs upon which the policy is based;
- the standards to be achieved; and
- how the policy standards will be met through working practices (procedure).

The Trust policy also states:

### Paragraph 2.11

“For those accepted for secondary services, the requirement for further support with engagement, coordination and risk management (i.e., needing CPA), will be indicated by the table of ‘Characteristics to consider when deciding if support of CPA needed’ (5.33) (Appendix 5)’”;

### Paragraph 2.14

“All service users requiring CPA will have an appointed care coordinator (5.33) (Appendix 4)’”;

#### Paragraph 2.16

“All service users subject to CPA will have a single care plan setting out clear details of who is responsible for addressing elements of care and support to help achieve service user’s aspirations, goals and preferred choices; and which includes a risk management plan (5.33) (Appendix 6)”;

#### Paragraph 2.18

“All care plans will be subject to regular planned reviews to measure progress in achieving desired outcomes (5.33) (Appendix 7)”;

#### Paragraph 2.24

“Transfers of care between Trust teams or other districts will be in accordance with the transfer protocol agreed by the North West Association of Directors of Adult Social Services (ADSS) Sub-Group of which Mersey Care NHS Trust is a partner. (5.8) (Appendix 10)”.

### **8.1 Analysis**

Although full CPA documentation was completed on 11 September 2011, Ms C was not allocated a care coordinator; this is not in line with Trust policy. Ms C did, however, receive regular coordinated care during the period she was being cared for by CRHT.

Staff told us in interview that CRHT would not immediately decide whether a new service user needed to be on full CPA. A care coordinator was not requested by the CRHT from the CMHT, indicating that one was not required and full CPA did not apply. When Ms C was transferred to the CMHT, she was seen only in outpatients: a care coordinator, again, was not required and therefore full CPA did not apply. When she was seen in outpatients on 2 November, it was confirmed that full CPA still did not apply.

An acute care plan (CPA 06) was completed with Ms C on 11 September 2011 and remained in place until 22 March 2012 when Ms C was seen at the police station after the incident.

Ms C’s care plan was not reviewed in October 2011 when she was transferred from CRHT to outpatient care, but it is unlikely that this omission had any bearing on the incident. Ms C’s condition had improved, and the task for the mental health service of monitoring her functioning with particular attention to depressive symptoms and compliance with antidepressant medication would have remained unchanged.

## **8.2 Conclusion**

Full CPA documentation was completed for Ms C, but she was not allocated a care coordinator and her care plan was not reviewed in October 2011 when she was transferred to outpatient care which is not in line with Trust policy. Despite this, we found that neither of these issues had any negative impact on Ms C's care and treatment or any bearing on the incident.

When we interviewed staff we heard that the Trust is implementing a new electronic records system. There is also some work being undertaken to revise the CPA process. We have however made a recommendation about the need for the Trust to provide assurance that the work they have undertaken is delivering the required service improvements.

## 9 Risk assessment and risk management

In this section we examine the risk management process followed for Ms C.

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. Risk management should be an integral aspect of CPA. The outcome of risk assessment should feed back into the overall clinical management.

*National best practice guidance in managing risk in mental health services* (Department of Health, 2007) sets out three risk factor categories. These are:

1. Static factors. These are unchangeable, e.g., a history of child abuse or suicide attempts.
2. Dynamic factors – those that change over time, e.g., misuse of drugs or alcohol.
3. Acute factors or triggers. These change rapidly and their influence on the level of risk may be short-lived.

The Trust policy and procedure for the use of clinical risk assessment tools dated June 2009 states in paragraph 1.3.1a that:

“Service users should expect that the clinical risks presented by them will be assessed and reviewed as often as deemed necessary in order that the risks identified can be managed effectively, safely and progressively over time.”

In paragraph 2.2.1 the policy describes the frequency of risk assessments and reviews:

“Service users should be assessed – or reviewed – at key turning points in their care pathway. Key turning points include but are not limited to the following:

- first referral to secondary mental health services
- re-referral due to a deterioration in mental state
- on admission into acute inpatient services
- pre-leave of absence trip from inpatient services
- pre-discharge from inpatient services
- when mental state or risk management appears to be deteriorating and the concerns of staff about the safety of the service user increase”.

In paragraph 2.2.2 it states that:

“Level One risk assessments will form the majority of the risk assessments undertaken, with Level Two assessments being relied upon for more complex or challenging cases, that is, those where there are competing problems or single problems that are severe in presentation or consequences. Level Three assessments will be utilised less frequently because of the time they require to complete. A Level Three risk assessment should be

considered when the service user's clinical presentation is complex (e.g., extensive psychiatric co-morbidity), risks exist in a number of areas or have the potential to result in incidents that are severe in their consequences for the service user (e.g., the client is a serious suicide risk) or others (e.g., the client is at risk of violence, sexual violence, intimate partner violence, stalking or harassment)."

## 9.1 Analysis

A systematic risk assessment using the Trust's CPA 05 risk assessment and risk history form was undertaken on 9 September 2011 when Ms C was first assessed by the service. The sections relating to suicide and self-harm and self-neglect were reliably completed with several 'current concerns' flagged. In the section dealing with offending behaviour and violence, a single current concern relating to paranoid delusions was noted. The assessor recorded:

"she no longer trusts anyone; she feels suspicious and has become increasingly more convinced that her partner is having an affair".

We found that no entry was made under the headings: 'Shared summary of potential for harming others (including trigger factors)' or 'Shared summary of potential risk to others'.

In light of this, it was concluded that Ms C presented "no risk to others".

An acute care plan (CPA 06) was completed with Ms C two days later on 11 September. It included the following crisis/risk plan:

"Should you ever experience overwhelming thoughts that may cause you to consider harming yourself or anyone else please do the following:

- Contact the CRHT [24 hour telephone details provided]
- You could tell a member of staff
- You should tell a family member or friend
- You can phone your mum for support who can then phone the CRHT".

We found no evidence that any subsequent systematic risk assessment was undertaken prior to the February 2012 incident. No revision of Ms C's risk management or crisis plan was systematically recorded, although changes to her treatment and management were documented in her notes and letters to her GP between September and November 2011.

The initial risk assessment undertaken in September 2011 failed to expand on the potential risk to Ms C's partner in the context of her paranoid beliefs about him but was otherwise completed to an acceptable standard. It is clear that the assessor did not at the time consider Ms C's partner to be at serious risk of harm from her. None of the clinicians who saw Ms C in the succeeding eight weeks thought otherwise, although we found no evidence of systematic risk assessment forms being completed.

Based on the evidence available in October 2011, the clinical judgements made by the mental health practitioners about the risk of physical harm to Ms C's partner were reasonable and appropriate.

Mental health staff interviewed Ms C's mother and partner. Neither reported any threats by Ms C to harm them. Staff never observed or reported any threats of harm to them either.

In the context of an obvious depressive illness with prominent symptoms, the risk assessments and Ms C's management plans were acceptable.

Ms C's risk assessment and care plan was not reviewed in October 2011 when she was transferred from CRHT to standard outpatient care, but it is unlikely that this omission had any bearing on the incident.

## **9.2 Trust progress**

Staff told us in interview that work has been undertaken in relation to risk assessment and management. A pilot for risk assessment training is taking place and, once evaluated positively will then be rolled out across the Trust. A redesign of the risk assessment process to be more formulation-focused has also been implemented providing a clear link between risk assessment and the most suitable management plan.

## **9.3 Conclusion**

Although the risk assessment of Ms C was not in line with Trust policy, it is unlikely that this had any bearing on the incident. The Trust has undertaken a lot of work on risk assessment and risk management since this incident, we have however made a recommendation about the need for the Trust to provide assurance that the work they have undertaken is delivering the required service improvements.

## **9.4 Recommendation**

The Trust should provide assurance that the reorganisation of services and the systematic changes being made deliver the required service improvements with a specific focus on handover of care, risk assessment, risk management and CPA.

## **10 Safeguarding**

The Trust corporate policy and procedure for the safeguarding and protection of children is dated 31 January 2006 and was reviewed in October 2011. It was in place at the time of the incident and includes key elements of national policy and best practice. The policy states:

“Every member of staff has an individual responsibility for the protection and safeguarding of children. All levels of management must understand and implement the Trust Safeguarding and protection of Children Policy and Procedure”.

### **10.1 Analysis**

Ms C had two children at the time of the incident. They were cared for largely by Ms C's mother. At Ms C's initial assessment on 11 September 2011, her mother verified that Ms C was attending to her children's needs. She did not raise any safeguarding concerns.

Following a discussion with Ms C's health visitor and CRHT staff on 19 September 2011, a referral was made to the safeguarding team by the CRHT to advise them of the CRHT involvement with Ms C. A joint visit involving the CRHT and the health visitor followed on 22 September. There was no indication of previous harm or neglect of her children and no clinical evidence of any intention to harm her children at any stage. No further contact was made with the safeguarding team.

### **10.2 Conclusion**

All the actions taken by the mental health service with respect to safeguarding were entirely appropriate.

## **11 Predictability and preventability**

In this section we examine whether the incident could have been predicted or was preventable.

### **11.1 Predictability**

We would consider that the homicide was predictable if we found there was evidence from Ms C's words, actions or behaviour at the time that could have alerted professionals that she might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time.

#### **11.1.1 Analysis**

Ms C had no history of violence. She never presented in a threatening or intimidating manner with staff. It is not possible to identify any aspects of her behaviour, words or actions between September and November 2011 that would have alerted staff that she would become violent imminently.

There was a failure to provide follow-up after 2 November 2011. After this date Ms C's treatment may possibly have altered in response to changes in her mental state or level or risk if she had been monitored.

#### **11.1.2 Conclusion**

Without any evidence about Ms C's mental state after 2 November we do not know if the incident could have been predicted if follow-up had occurred.

### **11.2 Preventability**

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but didn't take the steps to do so.

Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

#### **11.2.1 Conclusion**

Without any evidence about Ms C's mental state after 2 November we do not know if the incident could have been prevented if follow-up had occurred.

## 12 The Trust's internal investigation

The terms of reference for this investigation include assessing the quality of the internal investigation and reviewing the Trust's progress in implementing the action plan.

In this section we examine the national guidance and the Trust's incident policy to find out whether the investigation into the care and treatment of Ms C met the requirements set out in these policies.

### 12.1 The Trust's internal investigation

The good practice guidance *Independent investigation of serious patient safety incidents in mental health services* (NPSA, February 2008) advises that following a homicide an internal NHS mental health Trust investigation should take place to establish a chronology and identify underlying causes and any further action that needs to be taken.

The Trust's *Corporate policy and procedure for the reporting, management and review of adverse incidents* dated October 2011 states that "the management of adverse incidents is an integral part of the way the Trust meets its duty to minimise the risk to its service users, carers, staff and visitors".

The policy also states that a Level 3 chief officer's investigation will be undertaken when:

- "The incident is of a high public interest.
- Service users of the Trust have been involved in an alleged homicide incident.
- The incident fits the definition of one of the NPSAs<sup>1</sup> Never Events.
- The incident involved the death of a service user whilst they were an inpatient. Article two of the European Convention on Human Rights is likely to be engaged.

"The chief executive will agree the terms of reference for the incidents including the panel convened to facilitate the review, which will:

- Be chaired by an executive level member of staff.
- Have an independent/external representative.
- Have a service user/carer representative.
- Members will be representative of the professionals involved in the care delivery.
- Be supported by an administrator.
- The panel should not exceed more than five individuals.

"The report will be formally validated by the Trust Board.

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<sup>1</sup> National Patient Safety Agency

“Once the investigatory report has been completed, it will be validated by the Trust’s Adverse Incident Group, once the standard required has been achieved the report and associated action plan will be shared at the Trust Board. The Integrated Governance Committee will receive updates on progress as regards the implementation of the action plan on a six monthly basis”.

The policy also includes a statement about Being Open:

“The Trust fully endorses the Being Open agenda. Service Users and Carers will be actively engaged in the review of untoward incidents. Findings will be shared with them in an open, supportive and transparent manner – see the Trust’s Being Open Policy for further details”.

In this case, the Trust did commission an internal investigation review into the care and treatment of Ms C. The investigation was led by a non-executive director of Mersey Care NHS Trust.

The terms of reference for the internal review were:

“Two investigatory processes have been undertaken in respect of [Mr B] and [Ms C], but managed as part of one internal review. The review was required to:

1. Establish a chronology of the care and associated events leading up to the incidents allegedly involving [Mr B] and [Ms C].
2. Examine the quality and efficacy of the care and treatment provided to [Mr B] and [Ms C] by Mersey Care NHS Trust staff and in particular the processes used for and outcomes of: -
  - assessing the service users’ health and social care needs.
  - assessing risk and developing risk management plans.
  - communicating between services and planning such activities as discharge and/or transfer from one service to another.
3. To raise immediate concerns with the Liverpool Clinical Business Unit Director to ensure that any necessary remedial action can be taken without undue delay.
4. If deemed appropriate following initial evaluation of care and treatment, to consider any specific issues that the service users may wish to raise, with due regard to confidentiality.
5. To identify if there is a health care related root cause or influencing factors that contributed to the incident occurring.
6. To identify where improvements in practice/systems could be made.

7. To prepare two reports for the Board of Mersey Care NHS Trust”.

The investigation team consisted of:

- Non-Executive Director, Mersey Care NHS Trust (chair);
- Lead for Psychological Practice, Mersey Care NHS Trust;
- Complaints Lead, Mersey Care NHS Trust;
- Clinical Lead, Low Secure Unit, SaFE Partnerships CBU, Mersey Care NHS Trust;
- Acting Service Director, Addiction Services CBU, Mersey Care NHS Trust;
- Service user/carer representative; and
- Consultant psychiatrist /Medical Director, Cheshire & Wirral Partnership NHS Foundation Trust.

The Community Service Manager Liverpool CBU, Mersey Care NHS Trust, provided supplementary input to the preparation of the report.

#### 12.1.1 Analysis

The Trust commissioned a root cause analysis investigation in line with national and local good practice.

The terms of reference are clear and contain the names of those undertaking the investigation, but do not include the involvement of Ms C’s family or carers. In this case it may have been appropriate to involve Ms C’s parents with Ms C’s consent.

When we met with staff we were told that the Trust had taken on board duty of candour<sup>1</sup> and now always writes to relatives and carers to encourage them – with the service users’ consent - to be involved. The Trust also gives feedback to relatives and carers on the outcome of the report. In relation to contacting victims’ relatives the Trust told us that they would do this via the police liaison officer and that this has improved over the last two years.

#### 12.1.2 Conclusion

The Trust commissioned an internal investigation into the care and treatment of Ms C. The seniority of the investigation team was appropriate given the seriousness of the case.

The terms of reference did not include reference to the involvement of relatives or carers. In view of the progress that the Trust has since made in relation to engaging relatives and carers, we have not made a recommendation on this issue.

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<sup>1</sup> NHS providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

## 12.2 The investigatory process

The Trust investigation policy and procedures set out a clear process for undertaking an adverse incident investigation.

This policy details the responsibilities of the lead investigator and the ways in which staff should be involved in an investigation, including roles and responsibilities, checking for factual accuracy and sharing the findings.

### 12.2.1 Analysis

The internal review provides a selective chronology of contacts made by the Trust with Ms C between September 2011 and November 2011 when the last direct contact was made prior to the incident on 27 February 2012. The review omits details of eight visits made to Ms C by members of the CRHT in September 2011, thereby excluding relevant clinical information from its summary of evidence. It is unlikely, however, that its inclusion would have changed the review's conclusions.

The review does not fully address the issue of Ms C's mental health diagnosis and its possible relevance to her management.

We agree with the three areas of notable practice identified in the internal investigation:

1. Ms C was offered a first appointment within a little over two weeks, which was in line with CRHT protocol of a maximum of six weeks.
2. During the crisis period following Ms C being initially referred to CRHT, regular visits were made until she was showing signs of improvement, and there was effective joint working with a health visitor and consideration of other sources of support for women and families, in recognition of the potential impact of her difficulties on her two children.
3. The care team also considered safeguarding, sought appropriate advice and ensured safeguarding was included in the risk management plan.

### 12.2.2 Conclusion

The investigatory process could have been improved upon by including a complete chronology of contacts made by CRHT and by addressing Ms C's diagnosis and its relevance to her management.

## 13 Progress on implementing action plan

In this section we look at the Trust's progress in implementing the action plan arising from the internal investigation report.

The report identified three areas of notable practice as described above, several areas that needed improvement and made seven recommendations:

1. Handover processes between the access team and the CRHT team should be strengthened and consideration given to these teams being merged. Process should be in line with 'Refocusing CPA'<sup>1</sup> and be clearly defined in revised Trust policies and procedures.
2. The CRHT should aim to reduce the number of practitioners involved with each individual and ensure that a single named nurse oversees each person's care. (We acknowledge that changes in line with this recommendation may already have taken place.)
3. Risk assessment training and documentation should include reference to exploring the significance of jealousy and suspicion in relationships.
4. Systems for issuing repeat outpatient appointments should be reviewed to ensure people are routinely followed up in line with their plans of care.
5. Protocols for communication between primary and secondary mental health services need to be in place for when people are accessing both services.
6. Perinatal pathways should be reviewed, to ensure that the needs of mothers and their children are managed in the most effective way, including clarity about risk assessment and management responsibilities when multiple agencies are involved.
7. Enhance systems of support, to ensure that staff receive help and guidance immediately following a major incident.

### 13.1 Analysis

An action plan was developed to take forward the recommendations but the action was not allocated to a lead person and a timescale for completion was not identified. This is outlined in appendix B.

Since this incident the Trust has restructured the community services. The integration of CRHT and the AOT into community teams has taken into account the first two recommendations relating to handover processes and the number of

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<sup>1</sup> The Department of Health published *Refocusing the care programme approach* in March 2008. This document updates the guidance and emphasises the need to focus on delivering person-centred mental health care.

practitioners involved with Ms C. We heard at the interviews with staff that the merging of the CRHT with the CMHTs has improved the continuity of care for service users.

The Trust has undertaken a significant amount of work in relation to risk assessment and management. This has included training for staff and a redesign of the risk assessment process so that it is more formulation focussed, providing a clear link between risk assessment and the most suitable management plan. Domestic abuse is now included in the safeguarding training, and the domestic abuse policy is in the process of being reviewed.

We have previously described the work that has been undertaken in relation to outpatient appointments, and have made a recommendation in relation to ad hoc outpatient appointments.

The Trust now has a community of practice (CoP) promoting collaboration between primary care and secondary services. Primary care mental health liaison practitioners are working with GPs.

We have seen evidence that the perinatal pathway has been developed which refers to the NICE Guideline 45 for antenatal and post natal mental health. The pathway contains aims and objectives for the specialist perinatal mental health services, including referral processes, response times and discharge processes.

The Trust has developed its staff support service to provide the opportunity for staff to discuss any concerns they may have with a non-judgemental and impartial counsellor. Adverse incident reviews are asked to look at whether appropriate support has been offered to staff, and the Trust validation of incident report procedures would monitor that this has happened.

## **13.2 Conclusion**

From the evidence that we have seen, we are satisfied that the recommendations outlined in the Trust's action plan have been put in place to make improvements.

### Team biographies

#### Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises Trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people. Chris heads up Verita's office in Leeds.

#### Liz Howes

Liz Howes has 20 years' experience of senior management in the NHS, specialising in mental health and learning disabilities. Liz led on a service improvement project in mental health services as part of a national pilot with the National Institute for Mental Health in England, and was responsible for leading a multi-agency project to provide new homes for people with learning disabilities that promoted social inclusion and personalised care. Her previous posts have included Interim Director of Learning Disabilities and Specialist Services and Head of Services Redesign and Information Services at Leicestershire Partnership NHS Trust; and Director of Mental Health Services at Leicestershire and Rutland Healthcare NHS Trust.

## Trust action plan

**ACTION PLAN EMANATING FROM ADVERSE INCIDENT**

<b>Name of service user</b>	[Ms C]	<b>Incident Number</b>	<b>WEB 19865 STEIS 2012/7633</b>
<b>Date of Incident</b>	<b>27/02/2012</b>	<b>Report Date</b>	<b>August 2012</b>

<b>No.</b>	<b>Recommendation</b>	<b>Actions Taken</b>	<b>Evidence of completed recommendations</b>
1	Handover processes between the access team and the CRHT team should be strengthened, and consideration given to these teams being merged. Process should be in line with 'Refocusing CPA' and be clearly defined in revised Trust policies and procedures.	<ul style="list-style-type: none"> <li>• Communication processes between access and community teams are now more robust with the introduction of neighbourhood resource centres. Local services have integrated CRHT and AOTs into community teams as part of neighbourhood resource centres across the Trust.</li> <li>• This will also apply to the HMHLT who will refer directly to community services.</li> <li>• Referrals to community services in relation to criteria are being reviewed by the leads for community services.</li> </ul>	 shared care guidance - final.docx

No.	Recommendation	Actions Taken	Evidence of completed recommendations
2	The CRHT should aim to reduce the number of practitioners involved with each individual and ensure that a single named nurse oversees each person's care. (It is acknowledged by the review team that changes in line with this recommendation may already have taken place.)	CRHT staff have been fully integrated into community teams and are now care coordinators. Services have developed a stepped-up care approach for service users who come into crisis, with the care coordinator remaining as the main contact person. The issue with multiple practitioners will be addressed with this approach.	 shared care guidance - final.docx
3	Risk assessment training and documentation should include reference to exploring the significance of jealousy and suspicion in relationships.	<ul style="list-style-type: none"> <li>Domestic violence/abuse is covered in Level 2 &amp; 3 safeguarding training and the Trust has a domestic abuse policy &amp; procedure which is being reviewed on 28/04/14.</li> </ul>	  SD13-6Safeguarding Children Policy - uploz Abuse Policy 2011 Re   SD17-5SGA Safeguarding Vulnera
4	Systems for issuing repeat outpatient appointments should be reviewed to ensure people are routinely followed up in line with their plans of care.	The pending booking system was rolled out to all adult services across the Trust (as was). The system involves service users attending clinic and being advised verbally by the psychiatrist as to when their next appointment will be, for example, in three or six months' time. The service users pass this information on to the clinic receptionist on their way out, whereupon the receptionist advises them that a letter will be sent out by post 4–6 weeks prior to their next appointment date. Upon receiving this letter, service users will be able to choose and confirm their appointment by phone. This is in	

No.	Recommendation	Actions Taken	Evidence of completed recommendations
		<p>contrast to the previous, fixed system, whereby service users would be given their next appointment date on a card there and then at the clinic.</p> <p>A reminder service has also been implemented whereby service users are reminded of their outpatient appointment by letter one week before the appointment followed up by a telephone call the day before the appointment. Patients who have given consent to receive automatic appointment reminders as part of the automated reminder system (ARS) process will receive an SMS or voice reminder one week and then one day before their appointment date.</p>	
5	<p>Protocols for communication between primary and secondary mental health services need to be in place for when people are accessing both services.</p>	<p>The Trust now has a community of practice (CoP) promoting collaboration between primary care and secondary services. This includes 10 band 7 primary care mental health liaison practitioners working with GPs.</p>	
6	<p>Perinatal pathways should be reviewed to ensure that the needs of mothers and their children are managed in the most effective way, including clarity about risk assessment and management responsibilities when multiple agencies are involved.</p>	<p>The perinatal service is commissioned by Liverpool CCG and the Sefton CCGs, who pay Liverpool Women's (LWH). LWH then subcontracts an element to Mersey Care NHS Trust. The service specification was written by Liverpool CCG and covers the whole service, not just the part Mersey Care provides.</p>	 <p>Perinatal Service Specification 2013-14</p>

No.	Recommendation	Actions Taken	Evidence of completed recommendations
		<p>Mersey Care has been providing the service for some years but is still waiting for the signed 2013/14 contract to be returned by LWH; there have been a few changes of management which seem to be delaying things, although the Trust is still being paid for the service. The specification attached includes a few updates (in red) made by the Mersey Care team last year, which aware have been accepted by LWH.</p> <p>Any review of the overall pathway would be led by the CCGs (mainly Liverpool).</p>	
7	<p>Enhance systems of support to ensure staff receive help and guidance immediately following a major incident.</p>	<p>Staff support services are available to all staff at Mersey Care NHS Trust. Line managers provide immediate support for those involved in a serious incident and this should be offered to the whole care team. Adverse incident reviews are required to look at whether appropriate support has been offered to staff and the Trust validation of incident report procedures would pick up any anomalies.</p>	 5 Staff Support Services.doc