Pathway Review: Central and North-West London NHS Foundation Trust (CNWL) Mental Health Services, Milton Keynes

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EXECUTIVE SUMMARY

1. A Pathway Review was commissioned by NHS England (NHSE) to understand the service changes made after a serious incident involving a death several years ago. The perpetrator was a young man (X) who had been admitted informally via Street Triage with psychotic symptoms, but he left the ward without permission and police subsequently established that a young woman had been killed.

2. The aim was to understand: `*If a service user accessed services today with a similar history/problem, what would have changed/be different*? The work was informed by not only the initial investigation that was commissioned by the Trust, but also a more recent independent investigation. Together, this evidence shaped a focus on the way that people in an acute mental health crisis who need an admission are supported effectively, treated in partnership across the system of care, and are informed and engaged by their families and carers.

3. Understanding the organisational and staff changes that have taken place since the time of the incident was inevitably challenging. However, we noted several examples of excellent practice:

1.3..1 A `Safer Leave' project and a system of notation (traffic lights) on a `Risk Assessment Dashboard' now makes it easier for staff to see a patient's risk profile whilst on the ward.

1.3..2 A new checklist (The Dynamic Appraisal of Situational Aggression or DASA) is used routinely, recorded, linked to the patient's care record, and audited.

1.3..3 The wards have instituted daily `Safety Huddles', designed to give staff, a better understanding of the risks that may relate to patient safety.

1.3..4 Communications between the ward staff and community mental health teams have also been strengthened.

1.3..5 Communication and liaison between Trust staff and the Police have improved significantly and evidence-based checks and audits of performance show that this is having an impact.

1.3..6 Many new steps have been taken to improve the acute pathway, including a Single Point of Access (SPA), communications within and across the Crisis Resolution and Home Treatment Team (CRHTT), the Access Team, the Street Triage Team, the Crisis House, and a Crisis Line.

1.3..7 Primary Care Plus (a system designed to enhance mental health care for people with common mental disorders) has also meant that there are now more referrals from the various crisis points into primary care.

1.3..8 Provision of services for people with substance misuse and partnerships across and between NHS mental health services.

1.3..9 Stronger provision for carers and families to obtain better information and more support, particularly through the appointment of Carers Champions, and a wider range of teaching for staff.

1.3..10 The Trust has also strengthened and augmented records relating to staffing establishment numbers, absence, retention, turnover, and staff cover in the inpatient settings.

4. Our team believes that the arrangements to manage individual clinical and service-related risk assessments appear to be thorough and we applaud the care taken in the risk policy statement which chimes with the March 2022 NHSE Care Planning Position Statement.

5. Overall, and compared to the services available at the time, our team believes that several very positive steps appear to have been taken to strengthen services. However, our team also had several areas that we believe that the Trust should strengthen:

Recommendation 1
Consider with commissioners the scope to secure funding for ARC-MK (Addiction Recovery Community Milton Keynes) in Milton Keynes (ARC) to help retain staffing levels and ensure maintenance of effective mitigation of substance misuse problems.

Recommendation 2
Ensure that development and roll-out of DIALOG + is maintained and audited not just for the individual, but also in terms of the impact for families and carers. In this way, the impact of a very important step change in risk and care planning can be understood and managed.

Recommendation 3
Ensure that discussion continues to be undertaken with all parties, including Police, to support access to care for people with acute mental health problems presenting out of hours. This might be undertaken through development of a second bed in the S136 Suite, or perhaps by other means, to improve quality and safety for individuals in crisis who otherwise may wait much longer than is necessary.

Recommendation 4
Strengthen means to understand through audit the impact of the many developments designed to strengthen engagement and communication between the Trust and the families and carers living and working with people with severe mental ill health.

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1 Introduction

1.1 This report describes a Pathway Review (hereinafter called `the Review') that was commissioned by NHS England (NHSE) to understand more about current mental health care delivered in Milton Keynes at Central and North-West London NHS Foundation Trust ('the Trust'). The Review was undertaken to understand the service changes made after a very serious incident involving a death which took place several years before.

1.2 The perpetrator was a young man (X) who had been admitted informally[1] via the Street Triage Nurse[2]. He had florid psychotic symptoms including auditory and visual hallucinations, command hallucinations[3] relating to self-harm and delusional thoughts. X's symptoms had apparently been triggered in part by recent stressors (a split from his girlfriend, and the death by suicide of a friend). X was admitted for assessment, but he left the ward without permission. He did not return to the ward and could not be found; he later presented himself to the Police who subsequently established that an incident involving one of X's acquaintances, a young woman had been killed.

1.3 The Trust undertook an internal independent investigation which was completed in 2019 (delayed owing to a criminal investigation) designed to understand service provision, governance, quality systems, arrangements for identifying and escalating risks, and the opportunities for improving service quality. The perpetrator was found guilty of manslaughter due to mental ill health. The report judged that the death could not have been predicted. The report of the investigation made seven recommendations to strengthen services.

2 Methodology

2.1 Authority for Pathway Reviews and investigations into mental health-related homicide is set out in NHS guidance by NHSE and is available on the NHSE website[4]. Pathway Reviews focus on present day services and ask: `*If a service user accessed services today with a similar history/problem, what would have changed/be different*?' In this case, Terms of Reference (TOR) for the Review were agreed by NHSE[5] and the Trust. A group of professionals[6] ('our team') with experience of mental health services provision and relevant clinical qualifications

[1] 'Informally' means that he was not detained under the Mental Health Act (MHA).
[2] Street Triage is a CNWL service provided between 3pm and 2am with Thames Valley Police 7 days a week 365 days a year. A community mental health nurse is based at the Police station during these hours and provides advice and support to Police regarding people who may present experiencing mental ill health problems.
[3] Command hallucinations are auditory hallucinations that instruct a patient to act in some way; they can include instructions to self-harm or hurt someone else and may feel very compelling.
[4] NHS England and NHS Improvement (2015). The Serious Incident Framework: Supporting Learning to Prevent Recurrence'. https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf
[5] Annex 2 contains the Terms of Reference for the Review.
[6] Information about the team can be found in Annex 1.

was appointed in early 2023. In trying to capture the changes made over time, our team has focused mainly on those services which might be needed for someone in an acute mental health crisis presenting with psychotic symptoms.

2.2 Understanding the changes made to staff, policy and the organisational changes made in the Trust since the time of the incident was challenging. For example, since the time of the incident, the NHS has been reorganised (see the NHS Long Term Plan and NHS Mental Health Implementation Plan 2019/20 – 2023/24)[7] and Care Planning and risk assessment and risk management systems have been changed. Now, in this Trust, Community Mental Health Hubs are being developed to align with local Primary Care Networks; systems for accessing services, making a referral, or getting a response in a crisis, links with Police, Primary Care, systems to support carers, and deliver better engagement with families have all been developed. A significant number of staff in the senior team have also changed.

2.3 Our team therefore initially undertook a desktop review of documentary evidence[8] relating to, for example, risk policy, staffing, care planning, ward policies and governance arrangements to understand key elements of current learning and improvement as those related to the needs of someone with an acute, psychotic, severe mental health problem, clearly in need of treatment, supported at home by his family.

2.4 In addition to a review of relevant documents, we spoke to several staff, including[9] people at different levels of seniority with knowledge about adult mental health services with experience of working with people with severe mental ill health. Although none of the staff interviewed had been involved at the time of the incident, they were nonetheless able to address key questions about the way in which services had been developed and changed since that time. We are grateful to the staff who took a very open and constructive approach to the conversations with our team, including the opportunity to raise any concerns.

2.5 All those interviewed personally were contacted in writing with information about the investigation and its Terms of Reference. They were assured that their testimony would be confidential and that no personally identifying information would be included. Our team has no reason to doubt the reliability or validity of the evidence that was gathered on the basis of the documents or the interviews. All the staff who were involved in the development of this report had the opportunity to be involved in the Review and could comment upon a draft. At the time of writing, discussion is ongoing about the most appropriate way to share findings and communicate across the various governance systems and the Trust Board.

2.6 Representatives from NHSE ensured that members of X's family were also informed about the Pathway Review, and they were invited to be involved and/or informed. However, at the time of writing, they have not wanted to be involved.

[7] https://www.england.nhs.uk/mental-health/adults/cmhs

[8] Annex 3 contains a list of the documentary evidence reviewed.

[9] Annex 3 contains information about the staff who were interviewed.

3 Background

3.1 X's admission to psychiatric hospital had been arranged when Police who were alerted by X's odd behaviour contacted the Street Triage Nurse. There had apparently been several triggers for X's mental ill health, including low mood, suicidal ideation, anxiety and flashbacks relating to an assault. In addition, an acquaintance had taken his own life, X's girlfriend and he had been experiencing difficulties, and X's college work had not been going well. X was seen by the Duty Doctor, and he agreed to come into hospital as an informal patient for assessment.

3.2 X described the onset of his mental health problems to a head injury sustained in an assault three years earlier; he also reported a history of cannabis and alcohol misuse. It only became clear later that X had also had an extensive forensic history (not initially shared with the clinical team) which included battery, possessing a knife, ABH, possession of cannabis, damage to property and escape from detention.

3.3 X appeared calm when he was admitted. He was `clerked in' (the time was 1.20 a.m.), shown round the ward, he had some food, and was placed on intermittent observations[10]. X's Mental State Examination (a conversation with the doctor) included a risk assessment which noted information about the fact that X had formerly had thoughts of suicide but no plan to act, some evidence of elated mood, and evidence of abnormal thinking: for example, X said he had been reborn as Jesus and had eternal protection for dinosaurs. The plan was to assess X further and make a plan for his treatment.

3.4 X said he had not liked being on the ward and had wanted to go back to work. The staff encouraged X to remain on the ward for at least 48 hours to stay clean of cannabis and to enable a full physical assessment of his needs to be completed. On the day of X's admission, X's mother also visited the ward; she showed a staff member a recording she had kept of a telephone call which contained evidence of very disturbed thinking and threats from X towards her. The notes show that observations (every fifteen minutes) were maintained appropriately. During the day, X left the ward briefly for 15 minutes at midday, and again just after 3pm[11] . Section 17[12] leave forms were completed satisfactorily.

3.5 The Acute Home Treatment Team[13] advised that it would be better for X to remain in hospital until the Friday. Then, at just before 7pm, X left the ward again, but this

[10] Intermittent observations are generally used for patients who pose a potential but not an immediate risk. Staff observe patients at irregular and unpredictable intervals.
[11] Smokers are not allowed to smoke on the ward and patients normally go into the grounds.
[12] Section 17 Leave planning is based on the Mental Health Act Code of Practice guiding principles relating to least restrictive practice.
[13] The Crisis Resolution and Home Treatment Team (CRHTT) helps avoid admission to a mental health inpatient ward by providing intensive support to people in acute mental crisis in their homes, and works closely with the inpatient team and the out-of-hours urgent advice line.

time he did not return. Staff contacted X's mother, followed by the Police, but X could not be found. The incident was subsequently discovered when X presented himself to the Police station.

3.6 The incident shocked both families very deeply, because the family of X had, to the best of their ability, been providing support for X when his mental health deteriorated. Like the staff, the family had been unable to anticipate the degree of risk that X's symptoms were subsequently shown to represent.

3.7 The initial investigation that was commissioned by the Trust was delayed due to the need for criminal proceedings to take place but, once completed, thirteen `lessons for learning' were identified in five broad areas concerning:

- Listening to the Patient's mother's concerns about her son's behaviour state and engaging her in his treatment and care plan.

- Checking the Patient's collateral history.

- Having a robust system in place to support the family during the investigation process.

- The need for services to have a 'Think Family' approach.

- The need to ensure that learning from previous incident investigations within the mental health services is embedded.

3.8 The above `lessons for learning' were then shaped into seven specific recommendations:

- Arrangements for informal patients' leave.

- Timely communications about assessments from the Acute Home Treatment Teams to the inpatient teams.

- The role and function of the Family Liaison Officer in the Serious Incident Policy.

- Implementation of `Think Family'.

- The quality and recording of direct observations in inpatient care.

- Pathways to secondary mental health services from Police detention; information sharing and onward referral to forensic services.

The on-call system.

3.9 Alongside the TOR for the Review, these areas of Trust functioning represented foci for the work taken forward by our team. However, we also had access to information relating to a report of a separate Mental Health Homicide Review

(MHHR) commissioned in 2019'. This was of interest because the findings and recommendations resonated with those above, concerning the importance of:

- Taking a `whole family' approach.'
- Improving access to services (`One Front Door').
- Communications to and from A & E and MH care.
- Training for and about legal literacy.
- Liaison with the Criminal Justice System (the Police).
- Forensic pathways.
- Links to substance misuse services

4 Findings

4.1 In the following sections, the items in the TOR and recommendations arising from the initial investigation have been addressed in numerical order.

TOR items 1 and 2: review the comprehensive trust internal investigation findings, recommendations and Action Plan.

4.2 The Trust internal Investigation report was updated and finalised eighteen months after the incident. The work was undertaken by a small, senior team including a non-Exec Director, a Service Manager unrelated to the case, and a Borough Director, a senior nurse. The team was supported by a panel consisting of a Consultant Psychiatrist, the Head of the Serious Incidents Investigation Team and one of their team. Electronic records and strategic and operational policy documents were reviewed, members of the families (X's mother and members of the victim's family) were seen, and interviews with key staff were conducted. Information was also sought from X's GP (although none was forthcoming). The initial investigation team also spoke with X although he had little memory of the incident and was unable to describe very much about his care when he was unwell.

4.3 It was regrettable that the report of the initial investigation took such a long time (almost two years) to be completed. However, at the time, Thames Valley Police issued an explicit directive that whilst criminal proceedings were ongoing the families should not be contacted. Electronic records suggest that the families were then involved in an appropriate manner, and it appeared that the Trust met its Duty of Candour.

4.4 The seven recommendations made to strengthen learning were clearly articulated in the Trust Action Plan, which was expressed in operational terms, linked explicitly to those with responsibility for delivery, and dated and signed off by the Director of Mental Health and the Divisional Director. Information relating to learning was also included in the quarterly report for the Trust Board. Great care appears to have been taken to support all those who were affected by this tragic incident, including the staff who were directly involved, although no formal debriefing or review was undertaken.

TOR item 3: identify the issues arising from this case and carry out a review of the current pathway.

Informal patients leaving the ward.

4.5 When someone is admitted to psychiatric hospital, families are sometimes worried about safety and risk. In this case, and in the light of what followed, X's family raised a question about why X was allowed to leave the ward given that he was so unwell. Of course, we cannot know why X left the hospital ward against advice, and we cannot know the point at which X's symptoms escalated so rapidly that he represented a risk to others. However, based on the electronic record, it appears that X's assessment was delivered appropriately; it does not appear that he warranted detention under the MHA at the time he was assessed, and an appropriate level of supervision and observation appears to have been maintained during the short time that he was in hospital. However, it is also important to note that information relating to X's police record had not been provided to staff at the time he was assessed, and it is possible that a more cautious approach might have been taken had this been known. More information about the steps that have been taken to strengthen work in this area can be found in paragraph 4.13 *et seq* below.

4.6 To understand whether and how arrangements to manage unforeseen departures from the ward are now managed, our team discussed the matter with a senior representative: the Deputy Director of Mental Health with responsibility for oversight of the inpatient unit. Several changes have been made and our team believes that, were a similar case to be presented today, there are much stronger and more effective arrangements in place.

4.7 Firstly, steps have been taken to strengthen the way that staff assess and manage risk on the ward. A `Safer Leave' project has been implemented and a system of notation (traffic lights) on a `Risk Assessment Dashboard' now makes it easier for staff to see a patient's risk profile. Each patient is `rag-rated' or given a score of red, green or amber and this is completed for all patients regardless of their legal status, to improve the speed with which staff recognise a patient's level of risk.

4.8 Secondly, an approach (The Dynamic Appraisal of Situational Aggression or DASA) is now also used on the ward; this is a seven-item observer-rated actuarial risk assessment instrument used to assess the likelihood of aggression within the next 24 hours. As part of the strengthening of electronic records, all risks raised on Datix[14] are now linked to the patient's `Systm One' (the clinical record system used to record patient care electronically) and this is refreshed each morning in the Trust's Sharepoint system; any essential risk gaps are sent to the Ward Manager and Matron, copying the Service Manager and Deputy Director. Our team notes that the Trust has audited this process and whilst it appears to be robust, we urge the Trust to maintain it.

[14] Datix is a Risk Management Information System designed to collect and manage data on adverse events including information on complaints, claims and risk.

4.9 Thirdly, the wards have instituted a system of ` Safety Huddles': these are daily short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical and opportunities understand what is going on with each patient, and to help them understand the wider risks that may relate to patient safety such as bed availability, staffing levels, and whether, for example, admission checks have been completed. Staff report that Safety Huddles are an effective way to ensure that everyone working on the ward that day has full knowledge of any issues likely to cause concern and staff have welcomed this.

Communications between the Acute Home Treatment Teams and the inpatient teams.

4.10 The Trust has ensured that members of the community based Acute Home Treatment Team (AHTT) now known as the Crisis Resolution and Home treatment Team (CRHT) attend Ward Rounds/Ward Reviews routinely. The staff that we spoke to were clear that this has been helpful to improve liaison and communication. Other steps to improve engagement across the service have also been made. For example, the ward now gives out a list of upcoming discharges so that arrangements can be made in good time.

Pathways to secondary mental health services from Police detention, information sharing, and onward referral to forensic services.

Liaison between the NHS Trust and the Criminal Justice System (CJS).

4.11 Communication and liaison between Trust staff and the Police have improved significantly. At the time of the incident, no information about X's forensic history was independently available to the clinical team even though that history included possession of cannabis, damage to property, religious aggravation intentional harassment, escape from lawful custody, actual body harm and possession of an offensive weapon in a public place.

4.12 There was evidence to suggest that Section 136 (MHA)[15] cases were not managed very effectively. For example, such cases were resulting in a significant number what might be called non-mental health outcomes, or `false positives' (what is called the `conversion' rate). Five years ago (just after the incident) a Street Triage team was established, including a member of the police. S.136s were reduced to about 15-20 in total, with almost all showing a conversion – a clear indication that assessment and triage were both improving. Now, the overall number of S136s has been reduced and there is 100% conversion rate, meaning that people are being seen in mental health services when they need to be. This has been achieved by the Police and the nurses working together, by agreeing some basic training (Response Training), and by establishing routine monthly meetings: a programme which is called `Partnership in Practice'.

[15] Section 136 of the MHA Section 136 of the Mental Health Act 1983 allows a police officer to remove a person they think is mentally disordered and 'in immediate need of care or control' from a public place to a place of safety, in the interest of that person or for the protection of others.

4.13 Response Training (for police with NHS staff) has also been developed; this covers the Mental Health Act, Mental Capacity Act, custody and street triage (amongst other topics) and is now being rolled out more widely. Police and NHS staff report that it's possible to pick up the phone; have a more fluid, open dialogue, and ensure that people in need are referred more quickly to the right place. Our team also notes that changes will be developed in relation to the `Right Care Right Person' policy[16]. This is aimed at making sure the right agency deals with health-related calls. Instead of Police being the default first responder as is currently the case in most areas, the plan is for call handlers to receive training to triage calls and decide on an appropriate course of action, including whether to deploy police officers or not.

4.14 One potentially less positive aspect of the positive development of partnerships with police in the Trust, concerns the fact that there is only one S136 bed and one AMHP[17] on duty at a time; this means that if a bed is occupied and a second person is detained (although these are usually rare) there can be delays. Although we note that patients may be admitted in these circumstances to the Emergency Department, some staff told us that there can be delays, and it can be difficult to obtain a duty doctor; they believe that a second S. 136 bed is needed. It is possible that the impact of any delay has been felt more by the Police than the clinical staff, so our team was reassured to note that there is regular monitoring of S.136 use of the Health Based Place of Safety and discussion takes place in monthly multi-disciplinary Partnership in Practice (PIP) meetings attended by AMHPs, police, and members of the mental health teams. We also note that data is shared by Thames Valley Police and CNWL are part of the membership of the Strategic partnership group to manage health-based places of safety are coordinated across the Thames Valley. Our team urges the Trust to continue to discuss the matter with stakeholders.

TOR item 4: Review the development of the present-day service provision governance and quality systems, arrangements for identifying and escalating risks and opportunities for improving the quality of services.

4.15 Although it is difficult to identify the impact of initiatives such as those designed to improve Police/NHS liaison, and there are several initiatives (the SPA, the CRHTT system, the Access Team, the Street Triage Team, the Crisis House, and the Crisis Line) which strengthen the pathway from home into hospital and/or care and treatment. Primary Care Plus (a system designed to enhance mental health care for people with common mental disorders) has meant that there are now more referrals from the various crisis points into primary care.

4.16 The Trust has strengthened and augmented records relating to staffing establishment numbers, absence, retention, turnover, and staff cover in the inpatient settings; related to this, a pathway manager who is essentially a data

[16] https://www.met.police.uk/notices/met/introduction-right-care-right-person-model/

[17] AMHP means `Approved Mental Health Professional' approved by a local social services authority to carry out certain duties under the MHA responsible for coordinating assessment and admission to hospital under Section of the MHA.

analyst, now tracks cases and pathways in areas of obvious risk including allegations and serious incidents. This means that trends in information which may be important to the question of whether patients are safe from themselves and/or other people can be examined and understood.

4.17 Our team spoke with the Service Manager Crisis Pathway – Adult Mental Health with responsibility for operational delivery and development of street triage and the `crisis pathway'. The work covers an approximate population of 280k and includes development of a Single Point of Access (SPA) for people needing mental health care, Crisis Resolution and Home Treatment Team provision, liaison services between mental health and the acute hospital, the street triage team, links with the ambulance service, and links between the NHS and the CJS. Our team was also able to speak with two members of the police/liaison team.

4.18 Our team felt confident on the basis of discussions with staff, and on the basis of policy documents that the governance and quality assurance of investigations was overall of a good quality. Themed reviews are also undertaken periodically to explore issues that may be raised by families, patients or staff (examples include the way that ward-based direct observations are managed, and care planning).

4.19 Together with policies such as `Right Care, Right Person', these developments appear to be having an impact and waiting lists have gone down dramatically and our team was able to see audits of this information. For example, in the week that our team spoke with the data manager, she tracked 42 patients: about a third were discharged, and some had quite complex needs. Of those who were discharged, some were referred to IAPT, others to the Crisis Resolution and Home Treatment Team (CRHTT); some were allocated a Care Coordinator, some back to their GP. Now, a monthly data analysis meeting is held to review data quality and reports and audits can be triggered quite quickly and sent to the Trust Board via the quality and governance systems.

4.20 Staffing continues to be challenging and the Trust acknowledges a Covid legacy resulting in lower recruitment levels overall: a challenge faced by many Trusts across the country. Recruitment to posts at consultant level has been particularly challenging, particularly on one of the wards, there are now experienced fixed-term consultants recruited to both wards. Although the Trust has been able to use Band 5 and Band 6 posts more creatively. it also remains difficult to recruit to Band 6 (more experienced) nursing staff.

TOR item 5 Review and assess compliance with local policies, national guidance and statutory obligations for present day services.

Care planning

4.21 As has already been described, a significant level of development has been (and continues to be) taken to strengthen the way that care is planned and provided in mental health care in Milton Keynes. For example, the National Institute for Health

and Care Excellence (NICE)[18] published Quality Standard (6) concerning the way that people using mental health services should jointly agree a care plan with health and social care professionals and this was updated in 2019. National policy now sets out how each patient should have a statement setting out the needs of the person using the service, activities promoting social inclusion, and a plan containing what to do in the event of a crisis[19]. Five foci are identified to ensure that care is meaningful and intervention-based, provides a named key worker, delivers co-produced community care, support for carers, and is accessible and responsive.

4.22 Importantly, the new system does not have to conform to the Care Planning Approach (CPA) that was being used at the time of the incident which was criticised nationally as inequitable, rigid, and arbitrary. There is now no requirement for providers to use the CPA, nor any remaining metrics within national datasets relating to the CPA that are reported on or used for any purpose. Milton Keynes is therefore in the process of developing a new system, but this has only partly been implemented to date.

4.23 In Milton Keynes, CPA is being replaced with DIALOG +, an approach that was first trialled in the Trust in May 2022 and used in all the adult community teams since October 2022. DIALOG + is an evidence-based user-led process designed to record patient-reported experience (PREMS) and patient-reported outcome measures (PROMS) which directly assess the lived experience of service users. The aim is to capture perspectives on a person's health status and essential subjective constructs such as health, quality of life, goals, and social inclusion. DIALOG + consists of 11 questions upon which people rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. It gives a score for subjective quality of life and a score for treatment satisfaction. As such, the approach is more client centred.

4.24 When it operates properly, the DIALOG + process leads to an individual Recovery Plan which is more focused on looking at the positive rather than the negative aspects of care. The focus is solution-focused and based on strengths as well as needs. The system also more clearly identifies the social and familial or organisational factors which have a bearing on a service user's personal and clinical circumstances. As such, DIALOG + should strengthen the way that families and carers are involved because the plan would normally be copied for families/carers if the patient gives permission.

4.25 We urge the Trust to ensure that development and roll-out of DIALOG + is maintained, reviewed and audited to ensure that social, cultural, familial, and other patient-based information continues to be built into care, particularly in relation to the impact for families and carers.

Clinical risk assessment and clinical risk management in the inpatient service

[18] https://www.nice.org.uk/guidance/qs14/chapter/quality-statement-6-joint-care-planning
[19] https://www.england.nhs.uk/publication/care-programme-approach-position-statement

4.26 Clinical risk assessment for individual service users forms an important part of the network of risk management provided by the ward team. It sits alongside the more system-level risk management approaches (such as the Safer Leave project or Safety Huddles) above. At the present time in Milton Keynes, two different approaches for individual-level risks are used. DIALOG + is not used for the inpatient service. Instead, the Trust sets out a `Clinical Risk Assessment and Safety Planning Policy' which applies to all clinical practitioners employed within mental health, learning disability and allied services who have contact with service users. It is designed to be personalised, part of a crisis and mitigation plan, and includes arrangements for when a service user does not engage. Each service user has a care co-ordinator or lead professional who carries responsibility for ensuring that risk assessments, safety plans and communications are documented clearly in the progress notes.

4.27 The Risk Assessment protocol requires initially that the assessor (the lead clinical professional carrying responsibility for the patient) must check if there are any historical risk events such as an assault or an episode of self-harm. The assessor then completes a Risk Assessment Checklist covering items in seven categories: harm from others, harm to others or to property, deliberate self-harm, self-neglect, substance misuse, physical health concerns, contact with children, and risk of harm to children. A response of `Yes' in any of these categories triggers the assessor to complete a specific assessment. One of these (the Broset Violence Checklist, a validated tool) involves providing a score on risk behaviours which records information to show change. The Mental Health Governance team then completes monthly random checks.

4.28 Once an assessor has identified any/all-risk categories on the checklist, the service user's risk history is linked in the electronic record. The final step is then to complete a `Risk Summary' (a formulation) and a `Safety Plan` which describes how the risks and triggers interact. Ideally, this is designed to incorporate an overview of the service user's strengths and vulnerabilities as well as any risks and the factors that exacerbate or mitigate them, and includes static (e.g., historical) as well as dynamic factors (e.g., mental health or substance misuse related, loss, etc.,) that can have a bearing on risk. Policy states that a risk assessment should be completed on admission (within 72hrs), following a significant event, linked to a care plan, and whenever a patient is transferred or discharged (minimally annually). We note that the Trust has taken steps to ensure that care plans and risk assessments are audited routinely.

4.29 Our team believes that the arrangements to manage individual clinical and service-related risk assessments appear to be thorough and we applaud the care taken in the risk policy statement which chimes with the March 2022 NHSE Care Planning Position Statement which states: `*The National Confidential Inquiry into Suicide and Safety in Mental Health describes how, in order to make approaches to safety personalised and effective, assessments of (changing) personal and individualised risks should not be based on the use of tools and checklists. It is therefore important that assessment of risk forms part of a wider assessment, and that safety*

planning is built into the wider care planning process rather than being divorced from it.' The Trust has also developed a process to support the assessment of risk for patients seeking leave.

4.30 We also note the extract from October 2022 letter to mental health Trusts from the National Clinical Director for Mental Health which says`…We are asking all services to review the use of risk assessment tools and scales and develop highly personalised assessment and management of needs, risks, and contexts; what we would like to call safety planning…. we [also] advise services to refer to NCISH[20] guidance on assessment and response to clinical risk in mental health services, alongside NCISH's `10 Ways to Safer Services' recommendations.

4.31 However, we have a caution concerning the approach used for service users who are managed in the community when risks are present. This concerns the fact that, together with the fact that its content is predominantly service-user-led, DIALOG + contains more narrative than numerical information. Although it is important to note that DIALOG + contains a separate tool for risk assessment and does contain potential scope to gather information which is reported by staff rather than solely rated by the service user, we nonetheless urge the Trust to consider how best to represent risk information to an external view or for the purposes of audit and investigation going forward.

4.32 Our team would also like to urge the Trust to maintain its approach to careful audit of systems to manage clinical risk assessment and management to ensure that patients, carers, families and others associated with urgent care for people with mental ill health are supported effectively and consistently, and to ensure that safeguarding is provided where appropriate.

Services for people with problems of substance misuse

4.33 It is well known that mental ill health and substance misuse can co-occur. For example, in one significant study, as many as 42 percent of people who committed a homicide had a history of alcohol misuse or dependence, and 40% had a history of drug misuse or dependence[21]. At the same time, the historical separation of NHS or social care public sector services from the non-statutory services can create a dividing line between services, communication and liaison, and culture. Although substance misuse was not a focus for the recommendations made in this initial investigation, nor was it included as a focus in the TOR for the Pathway Review, the intervening investigation highlighted this area in 2019 as something that the Trust needed to address.

4.34 Our team was therefore very pleased to learn to understand more about the services provided by ARC-MK (Addiction Recovery Community Milton Keynes) in Milton Keynes. The substance misuse service which was formerly provided by a

[20] https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services

[21] https://pubmed.ncbi.nlm.nih.gov/16869841/#:~:text=Forty%2Dtwo%20homicides%20(17%25),contact%20and%20with%20stranger%20victims.

different organisation at the time of the incident, is a free, confidential addiction services for all adult residents funded in a partnership between public health and the mental health Trust. ARC accepts self-referrals as well as referrals from elsewhere (providing consent is given) through the Single Point of Access.

4.35 The service delivers assessment for people at any stage. Clients are screened initially to ensure that high risk individuals can be supported appropriately, and everyone has a physical health check. ARC electronic records are kept on *SystmOne* (the NHS electronic records system which is used in the Trust and in primary care) and this helps to ensure that communications and records are managed efficiently, and it ensures that KPIs are shared. Most people are seen within 3-4 weeks of referral.

4.36 Although ARC is not a mental health service as such, treatment is available and includes scope to support alcohol, drug or gambling difficulties. The service consists of (a) Health and wellbeing support which consists of psycho-social elements and a personal recovery plan with a Recovery Worker and a problem gambling clinic. (b) A needle-exchange (c) Ongoing testing for blood-borne viruses and (d) Nonmedical medical prescribing including substitution prescribing, and specialist detox and rehabilitation programmes in partnership with other organisations. In addition, there is a small team in the mental health inpatient service so that people with substance problems can be supported there, which also helps to ensure that referrals are managed effectively when people are discharged.

4.37 The substance misuse service in this Trust was as good as our team has seen anywhere else, and we urge the Trust commissioners to ensure that funding is maintained. Currently, the contract has been awarded for five years with an option of a two-year extension with occasional opportunities for additional funding due to, e.g., winter pressures which are time limited.

TOR item 6 Review the response to the concerns raised by the relatives and current practices around listening to relatives and ensuring their voices are heard (and implementation of `Think Family').

4.38 The Triangle of Care (TOC) is an approach which involves partnership between professionals, the person being cared for, and their carers. TOC is a therapeutic alliance between these elements of care, and the aim is to promote safety and recovery, and sustain wellbeing in mental health. The Trust Mental Health Services (community and inpatient) now have Carers Champions who provide a point of contact for carer information and take responsibility for identifying and supporting carers.

4.39 Families can make contact in several ways, including via the Carers Champions, and there are posters which explain the nature of the Scheme. Education, training, and development are significant components of the Scheme: for example, carers have been involved in sharing their journeys as part of the two MK Think Autism Conferences, and two Think Family Conferences. Carers are also regularly involved in interview panels, and their voices are heard in Young People and

Parent Forums to share their journeys and experiences as part of the local induction for medical students.

4.40 Carers MK provide an electronic copy of the teams' Carers Welcome Pack which can be given to carers containing details of the different ways to engage with services. In the past four years, there has been a significant increase in the number of carers involved in ward rounds, carer drop-in surgeries with the Ward Matrons, and information is routinely available about a range of topics such as `common sense confidentiality' (for carers and for staff) and `Carer Awareness'.

4.41 The Trust has also been working to strengthen information for families (regardless of whether they are listed as carers) to improve information and engagement. For example, `Engaged, Empowered, Involved', is a quarterly bulletin which covers action being taken across the mental health system of care (adults, children, psychological therapies, maternity, and other areas). The aim is to widen support for families such as peer support, through coffee and chat sessions, to build networks, improve health, and showcase progress. Conferences for staff have also been held (e.g., September 2022) to hear powerful and personal testimonies from patients and their families about their experience of services.

4.42 Issues relating to consent and information-sharing with families also represented a particular focus for the Trust recently following a case when a patient with physical issues was refusing to share information with the family. This provoked a significant development of learning, especially around the need to solicit information without breaching a patient's confidentiality.

4.43 Our team considers that the Trust appears to have strengthened significantly the ways that families and carers are engaged in the management and delivery of care, and it appears that the new system of care planning will further improve engagement in this area. We note that complaints have been reduced; the policy of `Right Care Right Person' policy has made a significant difference in that the number of re-referrals (what staff call: 'bounce backs') has gone down, and day-to-day checks of main key performance indicators are being managed more effectively. Interestingly, the use of videoconferencing which was used more during Covid has had the indirect benefit of making it easier for families to participate in ward meetings, and this has improved their dialogue with staff.

5 Conclusions and recommendations (TOR item 7: areas of good practice, opportunities for learning and areas where improvements to services may be required).

5.1 This report describes a Pathway Review of current care in Milton Keynes, part of Central and North-West London NHS Foundation Trust ('the Trust'), commissioned by NHS England and NHS Improvement (NHSE). The Review concerned services associated with care for people with severe mental ill health following a severe

incident when X left the ward before his assessment and treatment were fully established.

5.2 The Trust undertook an internal independent investigation which was designed to understand service provision, governance, quality systems, arrangements for identifying and escalating risks and explore opportunities for improving service quality.

5.3 It was challenging to identify or attribute the organisational and staff changes that have taken place since the time of the incident, and measure reliably and validly the ways that services for people with severe mental illness might now work for someone coming into the mental health service for the first time. We have therefore tried to make judgements based on a range of documentary evidence and a series of semi-structured interviews with a sample of staff. A significant range of organisational development has taken place (notwithstanding the exigencies of Covid which has slowed development in so many areas of NHS care).

5.4 Overall, and compared to the services available at the time of the incident, our team believes that several very positive steps appear to have been taken to strengthen services and these have been described in more detail in the body of the report; they include:

- Liaison between mental health staff and services and CJS staff.
- Provision of services for people with substance misuse and partnerships across and between NHS mental health services.
- The development of the Single Point of Access and the policy of `No Wrong Door'.
- Stronger provision for carers and families to obtain better information and more support, particularly through the appointment of Carers Champions, and a wider range of teaching for staff.

5.5 Our team also had several areas that we considered the Trust should strengthen; these have also been elaborated in the body of the report including:

Recommendation 1

Consider with commissioners the scope to secure funding for ARC to help retain staffing levels and ensure maintenance of effective mitigation of substance misuse problems - a frequent correlate of mental health problems in both community and inpatient services.

Recommendation 2

Ensure that development and roll-out of DIALOG + is maintained and audited not just for the individual, but also in terms of the impact for families and carers. In this way, the impact of a very important step change in risk and care planning can be understood and managed.

Recommendation 3

Ensure that discussion continues to be undertaken with all parties, including Police, to support access to care for people with acute mental health problems presenting out of hours. This might be undertaken through development of a second bed in the S136 Suite, or perhaps by other means, to improve quality and safety for individuals in crisis who otherwise may wait much longer than is necessary.

Recommendation 4

Strengthen means to understand through audit the impact of the many developments designed to strengthen engagement and communication between the Trust and the families and carers living and working with people with severe mental ill health.

Appendix 1

Terms of Reference for a Pathway Review into a historic case

Purpose of the Investigation

This review is aimed at examining the present-day situation. It will consider the service provision at the time of the offence and examine the learning/improvements that have subsequently taken place. It will ask the fundamental question of:

`If a service user accessed services today with a similar history/problem – what would have changed/be different?'

1. Review the comprehensive trust internal investigation findings, recommendations and action plan.
2. Review progress made against the action plan.
3. Identify the issues arising from this case and carry out a review of the current pathway with reference to these issues.
4. Review the development of the present-day service provision governance and quality systems, arrangements for identifying and escalating risks and opportunities for improving the quality of services.
5. Review and assess compliance with local policies, national guidance and statutory obligations for present day services.
6. Review the response to the concerns raised by the relatives and current practices around listening to relatives and ensuring their voices are heard.
7. The review process should also identify areas of good practice, opportunities for learning and areas where improvements to services may be required.
8. Provide a written report to NHS England that includes co-produced and agreed, measurable and sustainable recommendations.
9. Produces a learning document, suitable for sharing with other providers, on the learning from the investigation.

Appendix 2

The Investigation Team

Anne Richardson, Director of ARC, is a clinical psychologist by training who specialised in work with adults with severe mental ill health and long-term needs. Anne is an experienced teacher/trainer and communicator having worked as joint Course Director of the D Clin Psy at UCL and Head of Mental Health policy at the Department of Health. Anne was instrumental in the development of the National Service Framework for Mental Health and, with Sir Jonathan Michael, for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Anne chaired the Expert Reference Group (2016/17) for an investigation into deaths in Southern Health and has worked since 2010 as one of NHS England's providers of independent investigations.

Dr Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for inpatient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health, he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework. He worked until recently as a non-Exec in the north of England.

Adrian Childs started his career in Surrey in the mid-1980s, training as both a general and mental health nurse. He has been a director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust and his last post was as Director of Nursing at Leicestershire Partnership Trust. Adrian earned a distinction in his MSc at the University of East London in the mid-1990s; he also holds a diploma in leadership, mentoring and executive coaching. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. His previous experience includes serving as Deputy Chief Executive and Director of Nursing at Devon Partnership NHS Trust and Newcastle, Northumberland and North Tyneside Mental Health Trust. Most recently, he worked as interim DON at Avon and Wilts NHS MH FT. In 2014 he was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester.

Appendix 3

Documents reviewed.

Terms of Reference for the Milton Keynes Mental Health Services Directorate Senior Management Team (reviewed February 2022). To monitor, make decisions and provide assurance on matters relating to the directorate's finances, workforce performance and business transformation.

Milton Keynes Mental Health (MK MH) Care Quality & Innovation Forum (CQIF) To monitor, make decisions and provide assurance on matters relating to the directorate's finances, operational performance and contractual objectives.

Terms of Reference Terms of Reference CNWL MK Mental Health Clinical Oversight Groups (COGs) for the Acute and Crisis Services, and Community and Primary Care. These TOR provide clinical and directorate oversight of moderate and serious incidents, risk management, HDAPs, CQC action plans and peer review processes, and sign off service audits. The purpose is to share learning, innovation, quality improvement and provide assurance on matters relating to clinical quality compliance and safeguarding.

Risk Management Strategy and policy (Nov 2019 due for review Nov 2024)

Leave for Informal (Mental Health & Learning Disability) Patients Policy (Jan 2021).

Standard Operational Procedure for assessing patients prior to going on leave.

Ward Safety Huddle Procedure and arrangements for weekends.

Guide to Mental Health MK LPA – Revised Dec 2022 – Training document (NHS and CJS) relating to the MHA (S136, S135, S135 (2), S2, S3, S17, S17A, Police Powers to retake and additional Sections (S117) and Police powers to retake, the MCA, Place of Safety, etc.

MK CRHTT Crisis Resolution and Home Treatment Guidelines: assessing a patient using a biopsychosocial approach.

MK Clinical Risk Assessment Dashboard.

MK DIALOG and Care Planning Policy Approved Oct 22, due for review Oct 25.

DIALOG forms redacted.

Milton Keynes Mental Health Service Inpatient daily audit on staff carrying out enhanced observations 18 May 2023 to 24 May 2023.

MK Final RCA report (2019).

MK Ward Team meeting template to review inpatient care for individuals covering clinical, behavioural, medication-related, investigations, risks, observations, consent, and family issues.

MK Quality Committee Agendas and papers 2022-2023.

Appendix 4

Consultees

Head of the Serious Incident Review Team

Assistant Head of Serious Incidents Review Team

Representatives (2) from Thames Valley Police liaison team

Senior Manager ARC

Service Manager, Crisis Pathway

Nurse, Street Triage team

Service Director, Mental Health, Milton Keynes

Patient Pathway Manager

Clinical Director (Consultant Psychiatrist)

Head of Service User/Carer Engagement

Deputy Director for the Crisis Pathway (including Inpatient care).