An independent external quality assurance review following an internal investigation into the care and treatment of mental health service users A and B in North London

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Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Executive summary

1.1 Central North West London Foundation Trust (CNWL or the Trust) provides mental health services in North West London and Milton Keynes for all ages from children, to perinatal care for mothers, through to services for older adults with mental illness or dementia in a variety of settings.

1.2 On 7 March 2015 the Trust were alerted that service user B had been arrested for the alleged homicide of service user A. Service user B had stabbed service user A in the neck with a knife and she was later pronounced dead. Service user B was arrested and remanded in custody. He pleaded guilty to 'manslaughter by means of diminished responsibility' and was remanded in prison. He was convicted of her murder in May 2016 and received a life sentence.

1.3 The Trust conducted a serious incident internal investigation into the care and treatment of service user A and service user B in 2015. Service user B was the partner of service user A and they had been in a relationship for approximately 18 months. They had both been treated by mental health services provided by CNWL, although service user A was not in receipt of care and treatment at the time of the incident.

1.4 The internal investigation was convened by the Executive Director of Nursing on behalf of the Board of Directors to carry out a comprehensive, internal investigation in accordance with the NHS England Serious Incident Framework (March 2015).[1]

1.5 A Non-Executive Director was appointed to the panel and attended the initial panel meeting. The investigation subsequently proceeded with a panel comprising a Service Director, a Senior Consultant Psychiatrist and a Clinical Safety Manager.

1.6 The internal investigation was completed using root cause analysis methodology with the purpose of establishing any lessons that could be learnt in order to prevent future, similar incidents. The panel met for the first time on 13 May 2015 and the internal investigation was completed on 15 April 2016.

1.7 This extended timescale was authorised by NHS Harrow Clinical Commissioning Group (CCG) with a view to aligning the internal investigation with the Domestic Homicide Review (DHR) commissioned by the Safer Hillingdon Partnership in August 2015.

1.8 The internal investigation found that there were issues in relation to awareness of domestic abuse and the effects of potentially abusive relationships. Although staff were aware that service user A and service user B were in a relationship together this was not considered in the context of the relevant policies. Service user A had a young child who was under the care of the Local Authority Children and Families Services; there was limited communication between mental health services and social services and as a result joint agency working was poor.

[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf*

1.9 Additionally, it was identified that there needed to be an increase in the use of the Trust mental health initial assessment tool, more robust clinical risk assessment, formulation of risk management plans and documentation for patients who are discharged to the GP.

1.10 The internal investigation made 13 recommendations in respect of these findings, and the Trust additionally has two standard (fixed) actions following a serious incident which are to share the investigation findings with the patient (as appropriate) and the patient's family, and to share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams and services as applicable for the purposes of learning.

1.11 The Safer Hillingdon Partnership followed the statutory guidance for DHRs (2013) issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. The DHR was completed in July 2017 and the Overview Report and Executive Summary published accordingly.

1.12 The DHR found that service user B subjected service user A to physical violence and coercive control. The severity and frequency of domestic violence was escalating, which had also included violent assaults by service user B on his brother, and latterly an assault on a member of the public. The DHR found that it was reasonable to conclude that further serious violence could have been predicted. It could not have been predicted with certainty whom the victim would be, but the risks to service user A were elevated because they were intimate partners.

1.13 The DHR found that the services provided to service user A were not effective in keeping her safe. However, it could not be concluded whether, had the services been better coordinated, her needs been escalated and realistic and practical alternatives offered, and fewer opportunities missed, that the LA could have engaged effectively with agencies to ensure her safety and prevent her murder.

1.14 The DHR did not make the Trust subject to single partner recommendations however of the 12 multi-agency recommendations, two were relevant to the Trust.

1.15 The Trust was asked to provide assurance that they were compliant with the NICE guidelines on domestic violence and abuse[2] and to ensure that they had a policy on the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client.

1.16 NHS England London commissioned Niche Health & Social Care Consulting (Niche) to undertake an external quality assurance review, specifically to:

- review Trust progress on the implementation of action plans developed from the internal and DHR reports;

[2] *Domestic violence and abuse NICE 2016.* https://www.nice.org.uk/guidance/qs116

- assess the robustness of the Trust and CCG governance processes in managing and monitoring the action plans. Specifically, what structures are in place to ensure learning is embedded and whether changes have made a positive impact on the safety of Trust services; and

- highlight areas for further improvement derived from the above investigation, making recommendations for improvement as appropriate.

1.17 Niche is a specialist safety and governance organisation undertaking investigations into serious incidents in healthcare. Sue Denby, Practitioner, Governance and Investigations for Niche carried out the external quality assurance review, with expert advice provided by Kate Jury, Niche Partner for Governance and Assurance.

1.18 The investigation team will subsequently be referred to in the third person in the report. The report was peer reviewed by Dr Carol Rooney, Deputy Director, Niche.

1.19 The external quality assurance review has focused on the following key lines of enquiry:

- the implementation of the internal investigation and DHR recommendations;

- the impact of the action plan recommendations; and

- the governance and systems within the Trust.

1.20 The external quality assurance review commenced July 2018 and was completed February 2019.

1.21 We used the Niche Assurance Review Framework (NARF), to provide a well evidenced and rigorous assurance process.

1.22 In order to complete the review, we carried out a range of tasks including site visits, staff meetings, reviewing policies and procedures, and minutes of meetings and various reports.

1.23 The terms of reference for this external quality assurance review are given in full at Appendix A. Staff interviewed are referenced at Appendix B. Documents and policies reviewed are referenced at Appendix C. An overview of the Trust Hillingdon mental health services is referenced at Appendix D.

1.24 We have graded our findings using the following Niche criteria:

Grade	Niche Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.

C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

1.25 The external quality assurance review also reviews the DHR process of oversight, quality assurance of the final report and structures for learning lessons. We have summarised our findings in respect of these in the respective narrative sections of the report.

Structure of the report

1.26 Section 2 describes the process of the review.

1.27 Section 3 focusses on the implementation of the Trust's internal investigation action plan, and the two multi-agency recommendations relevant to the Trust following the conclusion of the DHR, to identify progress made against the action plan, to review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

1.28 In section 3 we have also included our review of the CCG monitoring of the action plan and the ensuing gaps in the process (3.25 – 3.69).

1.29 Further recommendation for improvement as appropriate are summarised both under each recommendation in turn and in the residual recommendations section of the report.

1.30 A summary is provided in section 4.

Assurance summary

1.31 It is acknowledged that this homicide has had far reaching effects on the Trust. Due to the major structural change within the Trust commencing in 2015, when this incident occurred, through to 2016-2017 as new services bedded down, we found it difficult to assess the assurance against the local actions very specifically, as structures and systems have changed considerably.

1.32 We have therefore assessed assurance as far as possible within the local Hillingdon mental health services, where applicable, and have provided further information about Trust assurance systems which have been put in place since then.

1.33 We found that the assurance for action 1b was subsumed in actions 1c and 1d.

1.34 In terms of the two fixed recommendations, the 15 remaining original report recommendations and associated Trust actions we have summarised the Niche grading totals as follows:

Grade	Niche Criteria	Number
A	Evidence of completeness, embeddedness and impact.	1
B	Evidence of completeness and embeddedness.	7
C	Evidence of completeness.	4
D	Partially complete.	3
E	Not enough evidence to say complete.	2
	Total number of actions	17

1.35 Where the action resulted in a grading of B, C, D or E we have made residual recommendations for the Trust to seek formal assurance of the completeness, embeddedness and impact against each action as appropriate.

1.36 We have made residual recommendations in respect of one of the fixed and the DHR recommendation.

1.37 In respect of Trust action 13, we have not made a residual recommendation as we are assured that the Hillingdon quarterly partnership report would highlight and enable action to be taken with access concerns.

Residual recommendations

Fixed recommendation

1.38 With reference to the fixed recommendation to share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams/services as applicable for the purposes of learning, we found it difficult to assess the specific impact of this fixed recommendation, as domestic abuse has not featured as a theme in Trust serious incidents, and the learning associated with this has therefore not been scrutinised.

1.39 We recommend therefore that the Trust includes a domestic abuse 'deep dive' when they review whether their approaches to learning are effective.

DHR recommendation

1.40 In terms of the Trust action in respect of the DHR recommendation, that the Trust 'Domestic Abuse Policy and Guidance' should contain guidance on the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client, we did not find the appropriate assurance to meet the DHR recommendation. We recommend that in the interim a clinical message of the week is utilised to advise staff accordingly until an amendment to the Policy can be actioned.

Trust action 1a, 1c and 1d

1.41 We recommend that the Trust includes a domestic abuse 'deep dive', when they review whether their approaches to learning are effective, to seek formal assurance of the embeddedness and impact of these actions.

Trust action 2

1.42 We recommend that the Trust seeks formal assurance of the impact of this action through the Quality Improvement (QI) workshops in Community Mental Health Teams (CMHT) to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.

Trust action 3

1.43 We recommend that the Trust seeks formal assurance of the embeddedness and impact of this recommendation through the QI project structure to improve the quality of clinical documentation, to ensure the initial assessment tool is being used as the basis for decision making.

Trust action 4

1.44 We recommend that, as a matter of urgency, the Trust assess the risk and develop Trust wide options to address the specific action for the Hillingdon mental health services to keep a register of all service users subject to child protection procedures and to appoint a children's and family services mental health champion within the services as the direct point of contact.

Trust action 5

1.45 We recommend that the Trust seeks formal assurance of the impact of this action this through the QI workshops in CMHTs to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.

Trust action 6

1.46 We recommend that the Trust seeks formal assurance of the impact of this recommendation, through the Trust wide improvements in the application of the Clinical Risk Assessment & Risk Management Policy.

Trust action 7

1.47 We recommend that the Trust seeks formal assurance of the impact of this recommendation through the regular sharing of the Hillingdon quarterly report with partners, which contains information on open cases, new cases, discharged cases, referrals into service and outcome, and percentage of accepted referrals seen within 28 days.

Trust action 8

1.48 We recommend that a task group approach is taken to the implementation of the final duty system within a three month timescale, with formal assurance provided of the completeness, embeddedness and impact of this action.

Trust action 9

1.49 We recommend that the 'unlicensed medicines' and 'off label' use' policy specifically with regards to the use of off-licence prescribing in personality disorder is subjected to audit by the Trust to seek formal assurance of the embeddedness and impact of this action.

Trust action 10

1.50 We recommend that the Trust seeks formal assurance of the completeness, embeddedness and impact of this action within three months, through auditing the daily zoning meetings notes, and by ratifying the draft MAPPA Policy including monitoring compliance.

Trust action 11

1.51 We recommend that the Trust seek assurance as to the impact of this action through the 2018-2019 North West London (NWL) commissioners quality schedule.

Trust action 12

1.52 We recommend that the Trust seeks formal assurance of the impact of this action through the Trust Business Intelligence Tool Tableau governance structure.

Trust action 13

1.53 We note that the Hillingdon September 2018 quarterly report, shared regularly with partners, contained information on open cases, new cases, discharged cases, referrals into service and outcome and percentage of accepted referrals seen within 28 days. We are therefore assured from this process that any concerns about access would be highlighted and action taken providing assurance of the embeddedness and impact of this action and have no further recommendation to make.

1.54 The summary of the original report recommendations, the Trust actions and the Niche gradings are as follows:

Number	Original Report Recommendation	Trust Action	Niche Grading
N/A	Fixed	Share the investigation findings with the patient (as appropriate) and the patient's family.	A
N/A	Fixed	Share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams/services as applicable for the purposes of learning.	B
1a	Hillingdon mental health services need to ensure that awareness of the risk of domestic abuse and the available local resources is increased and embedded into practice. This should include greater emphasis on assessing risk and indicators of domestic abuse during local safeguarding induction and training and should also incorporate information regarding key agencies and forums which support management of this risk.	Hillingdon mental health services will collate information from all domestic violence agencies in the borough and distribute to all teams.	C
1b	Hillingdon mental health services need to ensure that awareness of the risk of domestic abuse and the available local resources is increased and embedded into practice. This should include greater emphasis on assessing risk and indicators of domestic abuse during local safeguarding induction and training and should also incorporate information regarding key agencies and forums which support management of this risk.	The relevant agencies will be contacted and asked to attend a training session for staff regarding their role and objectives.	N/A
1c	As above.	Training to include greater emphasis on assessing risk and indicators of domestic abuse including how staff can ask the difficult questions.	C
1d	As above	Staff awareness to be further enhanced through displays of domestic violence public information in staff and public areas of the community bases.	C

Number	Original Report Recommendation	Trust Action	Niche Grading
2	The CMHT, which now incorporates the assessment and brief intervention team, need to ensure that where it is known that patients under the care of that team are in a relationship that this is discussed in clinical reviews. Systems need to be put in place to identify and manage the potential risks when individual patients are thought to be in a potentially abusive relationship with another patient, this should include links with partner agencies.	Discussion at local quality meeting and senior management team, reminding staff to record this in the relationship status part of the clinical record. Potential risks and links with external agencies to be placed on the alert management system of JADE.	B
3	The CMHT should use the adults mental health initial assessment tool to collate information obtained from the patients, carers, family and other agencies at the point of referral to the service. Clinicians should use the tool as the basis for decision making and care planning.	Following service redesign the adult mental health initial assessment tool is now used as standard. Operational Policy will be updated to make this explicit.	D
4	The CMHT should develop robust systems of communication with children and families social services wherever children are potentially at risk in consultation with children and families social services.	A register of all service users who are subject to child protection procedures will be kept by each team in Hillingdon mental health services. Children's and family services will be asked to specify a mental health champion within the services as the direct point of contact.	E
5	Where risk is evident, the CMHT seniors or consultants must set out a formulation with a statement of what responsibility lies with the clinical team and what responsibility lies with the patient. These actions should be clearly documented in the patients care plan and disseminated to all involved including the patients care plan.	Discuss and remind at care quality meeting that the statement of responsibility must be clear in the 'NB' section of records and also documented in clinic letters and care plans.	B
6	The CMHT must develop a system to ensure that clinical risk assessments are completed to the expected standard as per Policy for all patients.	A monthly peer review audit across all mental health teams with regard to the quality of risk assessments will commence.	B

Number	Original Report Recommendation	Trust Action	Niche Grading
7	A CMHT need to ensure that there is an effective system in place whereby patients who no longer require input from the team are closed on the patient electronic information system.	Administrative managers within teams will run monthly reports to establish activity within a four month period. This will identify closed cases on a monthly basis and the administrative manager along with the team manager will ensure these are closed from systems. Results from first run of the new system to be shared at senior management team.	B
8	The CMHT needs to review the role and responsibilities of the duty worker rota system to ensure that actions are always followed through, that updates are obtained and documented accurately.	Following recent community service redesign the duty system has been changed to reflect the need for continuity. This will be included in the Operational Policy for the teams.	D
9	CNWL medicines management group to ensure that all prescribers within the trust are made aware of the Policy in relation to off-licence prescribing.	CNWL medicines management group will send a memo reminding prescribers of the Policy.	C
10	The CMHT should ensure that where there is significant forensic history, including claims of a serious criminal nature of patients who come into contact with mental health services when a patient is known to MAPPA, there should be clear evidence of liaison by mental health services within this body.	Information received from MAPPA, relevant to current service users will be discussed at daily zoning meetings within the services.	E
11	The CMHT should ensure that patient discharge information is sent to all relevant professional teams and services.	Communication reminding staff of the need to ensure that the patient discharge communication is sent to all relevant professionals, teams and services will be sent to all staff. Discharge communication is sent using and MH5 form. An audit will take place to ensure that all relevant parties have been copied into this.	B
12	The CMHT should ensure that the practice of making clinical entries and sending written communication regarding outcomes of clinical reviews should be completed.	Communication reminding staff or the need to ensure that the practice of making clinical entries and sending written communication regarding outcomes of clinical reviews should be completed and sent to all staff. A randomised audit will take place specifically looking at the timeliness of entries.	B

Number	Original Report Recommendation	Trust Action	Niche Grading
13	The Hillingdon mental health services should ensure that all staff are made aware of that access criteria to their respective teams.	To ensure access criteria is included in the Operational Policy.	D

2 Assurance review

Approach to the review

2.1 The external quality assurance review has focused on the implementation of the Trust's internal investigation action plan and the two multi-agency recommendations relevant to the Trust following the conclusion of the DHR to identify progress made against the action plan, to review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

2.2 We have also included our review of the CCG monitoring of the action plan and the ensuing gaps in the process and made further recommendations for improvement as appropriate.

2.3 The external quality assurance review commenced in July 2018, was completed in January 2019, and was carried out by:

- Sue Denby, Practitioner, Governance and Investigations.
- Kate Jury, Niche Partner for Governance and Assurance.

2.4 This external review was comprised of a review of documentary evidence supplied and interviews with key clinicians and senior staff from the Trust.

2.5 We have graded our findings using the following criteria:

Grade	Niche Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

2.6 As part of our review we interviewed:

- Hillingdon Borough Director.
- Hillingdon Deputy Borough Director.
- Head of Serious Incidents Investigation Team.
- Associate Director of Quality, Safeguarding and Safety and Security.
- Associate Director for Quality Assurance, Improvement and Involvement.
- Safeguarding Lead.
- Assistant Director of Quality and Safety, NHS Harrow CCG.

- Hillingdon East CMHT Team Manager.
- Hillingdon East and West CMHT Office Manager.
- Hillingdon Team Manager West CMHT and Community Rehabilitation.
- Hillingdon Approved Mental Health Professional Social Work Team Manager East CMHT.
- Trust Safeguarding Children Advisor, Mental Health and Child and Adolescent Mental Health Services (CAMHS).

2.7 The terms of reference for this external quality assurance review are given in full at Appendix A. Staff interviewed are referenced at Appendix B. Documents and policies reviewed are referenced at Appendix C. An overview of the Trust Hillingdon mental health services is referenced at Appendix D.

2.8 The draft report was shared with NHS England, the Trust and NHS Harrow CCG. This provided opportunities for those organisations that contributed significant pieces of information to review and comment upon the content.

3 Action plan progress

Fixed recommendations

Number	Original Report Recommendation	Trust Action	Niche Grading
N/A	Fixed	Share the investigation findings with the patient (as appropriate) and the patient's family.	A

3.1 In terms of the fixed action to share the investigation with the patient (as appropriate) and the patient's family, we noted that the Care Quality commission (CQC) inspection report of August 2017 found that staff understood their responsibilities in relation to duty of candour and identified that staff were open and transparent with service users when something went wrong.

3.2 We reviewed the Trust Policy on Learning and Responding from Deaths (approved September 2017, review August 2020) and found this to contain a section on involvement of families and carers explaining the principles of being open and the duty of candour requirements.

3.3 To support the Trust Policy, we viewed the Goodall Division (which includes the Hillingdon mental health services) Standard Operating Procedure (SOP) for the Duty of Candour (January 2018) and found this to provide clear requirements, timeframes, clarity of responsibility and template letters following safety incidents where there is moderate, severe harm or death.

3.4 The SOP provides clear instruction on being open and duty of candour after an incident occurs and after enquiries into the incident are completed, including sharing learning, and an offer to meet the family in person to discuss the findings of the investigation and to provide the family with a copy of the report.

3.5 We were informed that there is no formal Trust process in place for supporting staff to communicate with the family during an internal investigation and the oversight of this is the responsibility of the Boroughs. The Trust does not have a formal family liaison officer role however the Boroughs are advised to identify a person to be the point of contact with families for every internal investigation and ideally within 24 hours of an investigator being appointed.

3.6 The Trust Incident and Serious Incident Policy provides guidance on the role of the family liaison officer. The Trust acknowledged that this person needs to be a senior clinician and we note that the Trust is discussing how to take forward the guidance produced by the National Quality Board (NQB) and NHS England on engaging with bereaved families.

3.7 We were informed that contact with the family during the course of an internal investigation was not, at the time, recorded on the Trust electronic serious incident system (DATIX) at the end of the investigation process as it is now, so we did not find a record of the family contact for this internal

investigation. However, we were informed that a meeting was held with the family for the LA to share the findings on 8 December 2016 with the author of the internal investigation report and the Deputy Borough Director.

3.8 The internal investigation report stated that at the request of the police the review panel had no contact with either service user B or his family during the course of investigation and the police advised the Trust that service user B and his family could only be approached following sentencing.

3.9 We note that in August 2015 the DHR process commenced, and the Trust submitted their internal investigation as part of the DHR process.

3.10 At this point, the criminal case for service user B was ongoing and the trial had not started. As a result, contact from the DHR panel chair with the perpetrator and his family was not attempted, however a letter was written to the family of service user A informing them that the DHR review was underway and giving them an opportunity to review the draft terms of reference.

3.11 A DHR family liaison officer was appointed by the Trust and following the sentencing of service user B in May 2016, contact was again made with the family for service user A and a meeting was held with them on 26 May and 8 November 2016. The draft DHR report was shared with the family of service user A on 10 February 2017.

3.12 The DHR chair also met with service user B's mother on 23 June 2016 and attempted to meet several times with service user B himself, however this was unsuccessful due to him being unwell and transferring between prisons at short notice. Service user B's brother declined to engage.

3.13 Given this, we met with service user B in HM Prison Wakefield on 16 April 2019 to provide information on the process and progress of the independent external quality assurance review. We confirmed that the DHR report would be forwarded to him, and arranged for appropriate prison support for service user B to review this.

3.14 Service user B told us that he had not been "quite right' since he was 17 years of age. He told us he had informed services that he would kill someone, and that drugs had played a part however "it was more than that". He didn't know what help he needed, felt "failed at every turn", lost trust and pushed services away.

3.15 Service user B suggested that more support was required for people with an "antisocial and anti-authority" personality disorder and his view was that more staff training was required.

3.16 We view the fixed action to share the investigation findings with the patient (as appropriate) and the patient's family as having been implemented by the Trust as far as possible, up to the point where the responsibility for this was overseen by the DHR chair on commencement of the DHR process in August 2015.

3.17 There are clear Trust and Goodall Division systems for the governance of being open and duty of candour requirements and given also that the CQC

found that staff understood their responsibilities in relation to duty of candour. We found that this fixed action had been implemented and the practice of being open and duty of candour was embedded.

3.18 We have found it difficult to assess the specific impact of this fixed action, however as a proxy measure we note from the Trust's November 2018 Family and Friends Test that 91 percent of people who responded would recommend the Trust to their friends and family should they require similar treatment.

3.19 We found assurance to meet this fixed recommendation and have therefore graded this as 'A' being completed, embedded and having an impact.

Number	Original Report Recommendation	Trust Action	Niche Grading
N/A	Fixed	Share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams and services as applicable for the purposes of learning.	B

3.20 In terms of the fixed action to share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams and services as applicable for the purposes of learning, we noted that the internal investigation report stated that the draft report was sent out to staff who contributed to the investigation to check factual accuracy.

3.21 We also noted that the final report was to be sent to the teams involved, Borough and Divisional Directors, the Trust board, Harrow CCG and NHS England.

3.22 We viewed the minutes of the Hillingdon Care Quality Group on 11 April 2015 which was specifically convened and focused on the internal investigation report and the recommendations and actions. The minutes indicate a full discussion about each recommendation and action in turn.

3.23 We noted the attendance at this meeting as being 18 staff members including Ward and Team Managers, Consultant Psychiatrists and the Head Occupational Therapist. We view the attendance as being an appropriate wide ranging group of multidisciplinary staff.

3.24 We noted 12 apologies including the Associate Medical Director, the Clinical Director, the Consultant Clinical Psychologist, the Borough Lead Pharmacist, the Head of Mental Health Services, the Quality Governance Manager, and some Team Managers and Consultant Psychiatrists. We view the apologies of some of the more senior staff members as unfortunate given the specific focus of the meeting, however, we were informed that at the time of this internal investigation the Divisional structure within the Trust had only been in place for a few months and was still bedding down.

3.25 To seek assurance against the fixed recommendation we undertook an end-to-end governance review of the serious incident process from when the incident occurred to when the internal investigation was completed and the action plan for the incident was closed. We looked at what should have happened against what actually happened, reviewed the CCG monitoring of the action plan and the ensuing gaps in the process.

3.26 We found that the timescale for completion of the internal investigation was delayed due to the Domestic Homicide Review (DHR). The panel met for the first time on 13 May 2015 and the DHR was commissioned in August 2015.

3.27 We found that authorisation for the extension to the internal investigation completion date was authorised by the CCG until 31 March 2016.

3.28 We were informed that as far as possible, when there is a parallel DHR process the internal investigation review will progress as planned. A decision to delay would be an open discussion regarding the issues but would normally be taken by either the Associate Director of Quality, Safeguarding and Safety or the Associate Director of Quality Assurance, Improvement and Involvement.

3.29 Due to the structural changes within the Trust, at the time of the incident, the Trust Serious Incident Team were responsible for managing the mental health serious incidents process and liaised directly with the Borough Director and investigator(s) with regards to all aspects of the process, while the Goodall Division Quality Governance Team continued to be responsible for managing the investigation process for all non-mental health incidents. These areas of responsibilities were in existence and had carried over from the period before the new Divisional structure was implemented.

3.30 To support the responsible person for managing the mental health serious incidents process, the Trust Serious Incident Team owned and managed the serious incident information tracker, however there was not a parallel serious incident process Standard Operating Procedure (SOP) in place at the time.

3.31 As a result of the state of flux between the new Divisional structures and the existing Trust structures for serious incidents in 2015, we found that the systems for managing and tracking serious incidents failed and this incident was not tracked through the serious incident process.

3.32 Subsequent to this period of structural change within the Trust, although the Trust Serious Incident Team continued to manage the investigation process for agreed categories of serious incidents including homicides, they were not involved in this particular incident as it had progressed to being near to completion at this point.

3.33 The Goodall Division now has a serious incident SOP in place which states that internal investigation actions should be added to the Goodall Division serious incident tracker overseen by the Goodall Head of Quality Governance which feeds into a Trust wide serious incident tracker. The Trust does not have a serious incident process SOP.

3.34 We were informed that the internal investigation report should have been submitted to the Borough Director and Clinical Director for review, comments and action planning and then to the Divisional Director of Nursing and Divisional Clinical Director for approval. We have not been able to find assurance that these steps in the process took place.

3.35 We found that the internal investigation report was submitted to the Executive Director of Nursing for approval in March 2016, that the Borough Director had approved the recommendations and action plan on 14 April 2016 and the Executive Director of Nursing finally approved the report on 15 April 2016. Although the final approval date was two weeks overdue, it would appear to be in roughly in line with the NHS Harrow CCG extension agreements to accommodate the DHR process.

3.36 We were informed that the internal investigation should have been presented to the Trust board part B and that part B board papers include a quarterly safety incident report including numbers, action plan completion and a high-level narrative. We have not been provided with the assurance that the internal investigation followed this process.

3.37 We were informed that the CCG have a serious incident panel which monitors numbers of serious incidents and action plan closure. However, the CCG was also in a state of flux with structural change in 2016, the serious incident panel was not in place and as a result, the internal investigation was therefore not discussed at the CCG or added to a CCG serious incident tracker.

3.38 At the time, the CCG serious incident tracker was a spreadsheet based exercise, however the CCG and the Trust now use an electronic serious incident monitoring system (DATIX). DATIX provides a better way of tracking when serious incident reports are due. It also allows for progress notes to be made when the CCG send back queries regarding the incident to the Trust. The Trust and the CCG are now exploring whether DATIX can be used to note when the last action on an action plan is completed to help prompt both the Trust and the CCG to seek assurance.

3.39 It has not therefore been possible to find appropriate assurance to support the closure of the action plan for the internal investigation although we have been informed that it is closed, despite the fact that recommendation four is viewed as ongoing due to further developments.

3.40 The Trust told us that since there has been a CCG substantive Director of Quality and Safety in post in the last year, the CCG now undertakes a quality assurance check on the internal investigation reports and comments, queries and seeks clarification with the Trust within a week of receiving the internal investigation report. This process is seen by the Trust as being supportively critical.

3.41 We found that neither the CCG nor the Trust use a formal quality assurance methodology for the internal investigation reports, although the Trust held an oversight day on 23 November 2018 to ensure that staff were informed about the methodology to use.

3.42 In 2017 the CCG Director of Quality and Safety reviewed how serious incident action plans could be monitored as it was acknowledged that this needed to be robustly managed.

3.43 The CCG is working with the Trust to explore different options as there are a large number of serious incidents reported and there needs to be a pragmatic approach to assurance on action plan closure. The Trust is exploring whether there is the need for added scrutiny by the senior team to review action plans reported by the Division as being closed. This is work in progress.

3.44 The CCG now hold a weekly serious incident group to review completed serious incident reports.

3.45 There is also a CCG Clinical Quality Review Group (CQRG) meeting held with the Trust every two months. Serious incidents form part of the set agenda and the Trust is required to submit quarterly patient safety reports. Currently within these reports, the numbers of action plans closed by the Trust are noted. There is no detail routinely provided about the incidents unless this is specifically requested by members of the CQRG.

3.46 In between the CQRG meetings, there is the opportunity for the Trust to present to commissioners, on key themes from incident reports to feed into the CCG quality schedule which is reviewed every two years. This was commenced in October 2018 as prior to this date, the CQRG meetings were taking place monthly.

3.47 In October 2018, the CCG requested the Trust to present on physical healthcare monitoring and ward activities as key themes. Risk assessments is another theme that has been highlighted and will be presented in one of the future sessions. The CCG may also ask the Trust to undertake a ‘deep dive’ into a theme.

3.48 We viewed Trust incidents, serious incidents and mortality quarterly reports to the Trust board which provide an overview of trends and themes and highlight the shared learning opportunities from incidents and serious incidents. We did not find that domestic abuse featured in this report.

3.49 The CQRG have a forward plan including thematic serious incident reports every quarter, patient safety reports every quarter, and an annual learning from deaths report. Learning from deaths is also provided on a quarterly basis as part of the quarterly safety reports.

3.50 The CCG may arrange an assurance visit to the Trust looking specifically at an action plan or at an arising serious incident theme. The CCG aim to undertake these announced or unannounced visits and agree these with the Trust. The assurance visits that have been undertaken before a serious incident report is due, have been as a result of safeguarding concerns or never events. The staff we spoke to in Hillingdon had not experienced a CCG assurance visit.

3.51 In terms of shared learning from this internal investigation, we viewed the Hillingdon CMHT Business Meetings and found that they have serious incidents and safeguarding as part of a standing agenda and that the

meeting of 27 July 2018 discussed the internal investigation and the action plan. Although this was headed as an update on recent serious incidents, the update was three years after this incident occurred, two years after the internal investigation was completed, and one year after the DHR was concluded.

3.52 We viewed the clinical message of the week dated 17 October 2018. This was specifically related to domestic abuse and the impact on children. It contained key points and advised staff to talk to their line manager or safeguarding lead to assess risks and formulate a safety plan. It signposted staff to the Trust 'Domestic Abuse Policy and Guidance' (approved August 2017, for review August 2020) and alerted staff to a domestic abuse learning event on 29 November 2018. We found that the staff in Hillingdon had seen the clinical message and were aware of the learning event. We saw that the clinical message of the week formed a standing agenda item at the Hillingdon CMHTs Business Meetings.

3.53 In terms of Trust wide systems for learning, we understand that the clinical message of the week aims to spread current learning across the Trust through a short two to three line message that is quick to read. Messages are drawn from current incident themes, serious incidents, policy updates and risk alerts. Learning is supplemented by providing feedback through emails, internal audit, meetings and learning walks. However, we were informed that there is no current electronic facility for Trust divisions to review other divisions completed internal investigation reports for the purposes of shared learning, however work is currently underway to develop a learning repository on the Trust intranet for the purpose of shared learning.

3.54 We were told that the quarterly Trust wide learning event aims to deliver a minimum of four learning events every year, supported by local Divisional learning events. The regular learning events provide a forum for staff to collaborate and discuss changes to improve quality in the services.

3.55 We saw that the Trust had delivered previous learning events on putting patients and carers at the centre of their care, working to reduce harm across community and mental health services specifically on suicide prevention, and pressure ulcer prevention and management.

3.56 In March 2018, the Trust held a Quality Priorities Workshop. The aim was to share learning, ideas and innovations, and to discuss Quality Priorities over the coming year. In July 2018, the Trust held a learning event for governors on Quality and Safety. During the year, a number of staff involvement initiatives took place in each of the three divisions to support sharing learning and staff engagement.

3.57 To support Trust wide learning and improvement generally, the Highlight and Organisational Learning Annual Report 2017/18 presented to the Trust Board in July 2018 stated that in November 2017, the Trust started a new Trust wide QI Programme working with The Institute for Healthcare Improvement (IHI) as strategic partners. This programme uses the QI methodologies and the science of improvement to improve the services the Trust provides to patients and carers.

3.58 In July 2018 the Trust recorded 182 projects on the QI system with key areas for improvement clustered around improving clinical effectiveness, access, patient and carer experience and patient safety. We noted that teams and services across the Trust are embracing the QI model in order to support measurement of interventions, which are aimed at improving and sustaining patient safety.

3.59 The Trust continues to learn from patient experience and listen to their feedback, through Patient and Carer groups, the Carer's Council, The Patient Reference Group, and the Joint Patient and Carer Feedback Group, which reviews patient feedback on a quarterly basis. Additionally, the Trust has patients and carers in attendance at Trust board meetings to tell their story. Actions are followed up, and the Trust opens every monthly operational board meeting with a learning story.

3.60 The operational board is attended by senior divisional leaders and is utilised for cross divisional learning, and the Trust Mortality Review Group (MRG) meets monthly and also provides a platform for learning. The CCG form part of the membership for this group. The group monitors mortality data and a number of learning themes have been shared within the organisation and relevant actions have been taken. Details of the learning from the MRG are regularly reported to the Quality and Performance Committee and in the Trust annual quality account.

3.61 The Organisational Learning Plan for 2018-2019 presented to the Trust board in September 2018 states that the Trust will test whether learning is effective by tracking whether or not similar incidents and feedback is repeated through the year and by seeking staff feedback to adapt their learning approaches.

3.62 In summary, we found that the CCG is working appropriately with the Trust to explore different options to assurance on action plan closure.

3.63 We found that the Hillingdon East and West CMHTs had discussed this incident, recommendations and action, that domestic abuse had featured in a Trust clinical message of the week and that a Trust learning event on domestic abuse had been held, although all of these had taken place three years after the incident had occurred, two years after the completion of the internal investigation and one year after the publication of the DHR.

3.64 We found that learning from this incident had prompted a review and changes to the Trust 'Domestic Abuse Policy and Guidance' (approved August 2017, for review August 2020).

3.65 The CCG told us that they find the Trust to be very transparent and open, apply good internal challenge at mortality meetings and they are very open to the CCG attending their internal meetings.

3.66 We considered the Trust wide structural changes that took place in 2015–2016 and although staff told us that sharing learning across the Trust is a constant challenge, we found that the Trust does now have appropriate systems for sharing learning in place and for reviewing whether the approaches to learning are effective.

3.67 We found assurance that this fixed recommendation has been implemented and embedded in practice and have therefore graded this as ‘B’.

3.68 However, we found it difficult to assess the specific impact of this fixed recommendation, as domestic abuse has not featured as a theme in Trust serious incidents, and the learning associated with this has therefore not been scrutinised.

3.69 We recommend that the Trust includes a domestic abuse ‘deep dive’ when they review whether their approaches to learning are effective.

Recommendation 1a

Number	Original Report Recommendation	Trust Action	Niche Grading
1a	Hillingdon mental health services need to ensure that awareness of the risk of domestic abuse and the available local resources is increased and embedded into practice. This should include greater emphasis on assessing risk and indicators of domestic abuse during local safeguarding induction and training and should also incorporate information regarding key agencies and forums which support management of this risk.	Hillingdon mental health services will collate information from all domestic violence agencies in the borough and distribute to all teams.	C

3.70 We saw that Hillingdon mental health services had collated information from all domestic violence agencies in the borough. This information was in electronic form, available to staff as required and included information from the following agencies:

- Southall Black Sisters.
- Ashiana Project.
- Broken Rainbow for LGBT.
- Deafhope.
- Women’s Aid Helpline.
- Hillingdon Domestic Abuse Floating Support.
- Refuge Space.
- Emergency Refuge Space.
- Emergency Housing Out of Hours.
- Victims of Domestic Violence in Crisis.

- Police Community Safety.
- Know Where To Go Directory
- Men's Advice Line.
- National Centre for Domestic Violence.
- London Borough of Hillingdon Services.
- Victim Support.
- Independent Domestic Violence Advocacy Service.
- Advocacy after Fatal Domestic Abuse Support.

3.71 The information available included a short statement of purpose for each agency and referral information. We also viewed a patient information leaflet, created by the Metropolitan Police Service (MPS) which is available for use in the Trust.

3.72 We found April 2016 and May 2017 email evidence that staff across the Trust and in Hillingdon specifically had been provided with information about local domestic abuse support and advice contact information.

3.73 We therefore found assurance that the action had been implemented and graded this as 'C'. The Trust needs to continue to seek formal assurance of the embeddedness and impact of this recommendation, and we recommend that the Trust includes a domestic abuse 'deep dive' when they review whether their approaches to learning are effective.

3.74 In relation to impact of this action, this grading should be seen in relation to the assurance for the actions associated with recommendations 1c and 1d.

Recommendation 1b

Number	Original Report Recommendation	Trust Action	Niche Grading
1b	Hillingdon mental health services need to ensure that awareness of the risk of domestic abuse and the available local resources is increased and embedded into practice. This should include greater emphasis on assessing risk and indicators of domestic abuse during local safeguarding induction and training and should also incorporate information regarding key agencies and forums which support management of this risk.	The relevant agencies will be contacted and asked to attend a training session for staff regarding their role and objectives.	N/A

3.75 The assurance the Trust provided against this action did not correspond appropriately to 1b. However, it was relevant to and included in the actions associated with 1a and 1c.

3.76 We have therefore not graded this particular action.

Recommendation 1c

Number	Original Report Recommendation	Trust Action	Niche Grading
1c	Hillingdon mental health services need to ensure that awareness of the risk of domestic abuse and the available local resources is increased and embedded into practice. This should include greater emphasis on assessing risk and indicators of domestic abuse during local safeguarding induction and training and should also incorporate information regarding key agencies and forums which support management of this risk.	Training to include greater emphasis on assessing risk and indicators of domestic abuse including how staff can ask the difficult questions.	C

3.77 In assessing whether training included greater emphasis on assessing risk and indicators of domestic abuse including how staff can ask the difficult questions, we noted both the Trust Highlight and Organisational Learning Annual Report 2017-2018 which stated that the Trust had consistently met the statutory and mandatory compliance target for safeguarding adults training for three consecutive years, and the CQC comment in the August 2017 quality report that safeguarding processes are robust, and staff have received appropriate training.

3.78 Additionally, we noted that the Trust completes the Safeguarding Health Outcomes Framework[3] (SHOF) quarterly for each CCG and it is presented to each Local Authority at partnership boards, providing consistency for partner agencies on the safeguarding work that the Trust is undertaking.

3.79 As part of the DHR multiagency recommendations, the Trust was asked to provide assurance that they were compliant with the NICE guidelines on domestic violence and abuse and to ensure that they had a Policy on the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client.

3.80 We confirmed that the Trust has a specific Policy entitled 'Domestic Abuse Policy and Guidance' (approved August 2017, for review August 2020) based on the National Institute for Clinical Excellence (NICE) Quality Standards (2016) for Domestic Abuse and which sets out clearly the key points of the Policy as:

- All members of staff have a responsibility to respond to domestic abuse.
- People presenting to frontline staff with indicators of possible domestic abuse are asked about their experiences in a private discussion.
- People experiencing domestic violence abuse receive a response from level one or two trained staff.

[3] https://www.adass.org.uk/media/6525/msp-outcomes-framework-final-report-may-2018.pdf. *A means of promoting and measuring practice that supports an outcomes focus for safeguarding adults work.*

- Responses to domestic abuse should put safety first and include safety planning.

- People experiencing domestic abuse are offered a referral to specialist support services.

- People who disclose that they are perpetrating domestic violence or abuse are offered a referral to specialist services.

- Domestic abuse should be discussed regularly in staff meetings and supervision so that all staff members feel confident in responding to the issue.

3.81 The policy is clear on the indicators of domestic abuse and the risk factors and has a section on asking the question about domestic abuse, with examples of how the question may be framed and followed up more directly. There is a routine enquiry template on the new electronic care notes system (SystmOne) which has already been in use by CNWL physical health care services in Hillingdon (for example with District Nurses) for a number of years. CNWL Mental Health services started using SystmOne in January 2019. The work required to implement routine domestic abuse enquiries is a key aim for the Trust in 2018-19.

3.82 However, we could not find a section within the policy providing guidance about the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client. There is a section, which could be seen as relevant, on referring high risk cases to an Independent Domestic Violence Advisor (IDVA) which should be offered to all service users who disclose domestic abuse or where domestic abuse is identified.

3.83 An IDVA is independent from statutory agencies such as the police or social care. They will work with survivors to assess the level of risk, discuss a survivor's options and support them to make safety plans. IDVAs can support survivors with housing, criminal and civil options, benefits, counselling etc. IDVAs are non-judgmental and non-directive with a goal of empowering a survivor to make their own decisions.

3.84 Survivors must consent to a referral to the IDVA. Once consent is gained the staff member should contact the IDVA via telephone or email. Upon successful contact with a survivor, the IDVA will complete a detailed risk assessment and safety plan and can work in liaison with staff to support the survivor. Survivors can also self-refer to IDVA services. Local IDVA contact details are available in the Policy.

3.85 There are currently pilot projects within the Trust to co-locate IDVA services and staff on a sessional basis so that any concerns a staff member may have around a patient experiencing abuse can be discussed, to explore support options and services available in order to support the patient around minimizing the risk of abuse, to discuss the potential level of risk of abuse to the patient and next steps, and to provide specialist in-house consultation/training to Trust mental health staff around domestic abuse.

3.86 As of 8 January 2019, the CNWL acute mental health wards and the mental health in-patient rehabilitation unit in Hillingdon now have access to an IDVA, who is based at Hillingdon Hospital in the A&E department.

3.87 We were told that general level 1 adult safeguarding awareness training used to be included within the induction period for new staff, however due to structural changes within the Trust staff now have to complete two and a half hours of on line adult safeguarding training within four weeks of commencing employment with the Trust. In addition to this, three hours of face to face adult safeguarding training is provided, face-to-face or on line, with refresher training provided every three years. Staff told us that they would like refresher training to be provided annually, however we were informed that the Hillingdon Safeguarding Lea visits each of the services in Hillingdon on an annual basis to provide a basic refresher session for staff with regards to safeguarding adults and the MCA.

3.88 Adult safeguarding training figures are monitored monthly and additional sessions are provided to targeted areas. In December 2017 the Trust was exceeding the 90 percent target set by the lead CCG. The Goodall Division training figures were 98 percent for both level one awareness and level two clinical staff adult safeguarding training and we noted that reports indicate that Goodall Division consistently exceeds the Trust target for mandatory and statutory training.

3.89 We viewed the Hillingdon Safeguarding Adults Board safeguarding adults training programme for 2018–2019 and found that the courses available included training in domestic violence and intimate partners. We noted a poster in the staff area of the team base which provided staff with details about this course specifically, and we also viewed a November 2018 conference poster about children and domestic abuse.

3.90 Specifically related to this internal investigation, the Trust provided us with assurance that an organisation called Standing Together[4] was commissioned to and provided seven sessions of domestic abuse training covering 95 staff members in Hillingdon through 2016 and 2017. These sessions included understanding the dynamics of an abusive relationship, the skills and tools to support survivors of domestic abuse and engaging with domestic abuse perpetrators.

3.91 Standing Together Against Domestic Violence is a UK charity bringing communities together to end domestic abuse. In 2016, a post was funded for two years to support the domestic abuse agenda in mental health services in Hammersmith and Fulham, Kensington and Chelsea and Westminster. As part of this role domestic abuse training was provided to mental health staff in these boroughs, which was then extended so that it was available to any mental health member of staff in CNWL. In total, seven face-to-face domestic abuse sessions were provided to mental health services in Hillingdon and 95 members of staff were trained through 2016-17. The funding for this post has now come to an end.

3.92 As a result of this internal investigation, the Hillingdon Safeguarding Lead

[4] *http://www.standingtogether.org.uk/about-us. Standing Together is a UK charity bringing communities together to end domestic abuse.*

provided us with the information used in the Trust adult safeguarding training on domestic abuse. This information provides staff with a description of domestic abuse and the forms it can take, plus information about the Serious Crimes Act 2015 and the requirement to undertake routine enquiry about domestic abuse for all female patients and selected enquiry for men.

3.93 The Hillingdon Safeguarding Lead attends all team business meetings on an annual basis to provide adult safeguarding refresher training of about 20 to 30 minutes duration. We viewed the team visit schedule provided which included dates and areas discussed and we noted that the Hillingdon Safeguarding Lead was due to visit the East and West Hillingdon CMHTs in January 2019.

3.94 These annual visits allow staff to discuss questions and concerns about adult safeguarding and domestic abuse, including how to ask the question about experience of domestic abuse which some staff my find difficult.

3.95 We noted that the Trust held a domestic violence and abuse learning event on 29 November 2018.

3.96 In summary, we found that the Trust has a specific Policy entitled 'Domestic Abuse Policy and Guidance' based on the NICE Quality Standards (2016) for Domestic Abuse, however with reference to the DHR recommendation, we could not find a specific section within the Policy providing guidance about the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client. We recommend that this is addressed in the interim through a clinical message of the week.

3.97 We found good assurance that adult safeguarding training did include greater emphasis on assessing risk and indicators of domestic abuse including how staff can ask the difficult question, and we have therefore graded this action as 'C' having been implemented.

3.98 However, given that routine enquiry has yet to be rolled out within the Trust we have not been able to say that this has been embedded in practice, nor have we been able to assess the impact of the training.

3.99 The Trust needs to continue to seek formal assurance of the embeddedness and impact of this recommendation, and we recommend that the Trust includes a domestic abuse 'deep dive' when they review whether their approaches to learning are effective.

Recommendation 1d

Number	Original Report Recommendation	Trust Action	Niche Grading
1d	Hillingdon mental health services need to ensure that awareness of the risk of domestic abuse and the available local resources is increased and embedded into practice. This should include greater emphasis on assessing risk and indicators of domestic abuse during local safeguarding induction and training and should also incorporate information regarding key agencies and forums which support management of this risk.	Staff awareness to be further enhanced through displays of domestic violence public information in staff and public areas of the community bases.	C

3.100 We saw that Hillingdon mental health services had public displays of domestic violence public information in staff and public areas of the community bases. This included information about the many forms of domestic abuse and information about out how to report it or seek support including in an emergency.

3.101 Domestic violence, adult safeguarding staff training information and dates for forthcoming associated events was also displayed in the Hillingdon East and West team base

3.102 We therefore found that the action had been implemented and graded this as ‘C’. However, public displays of domestic violence information does not mean that staff awareness is embedded in practice. The Trust needs to continue to seek formal assurance of the embeddedness and impact of this recommendation and we recommend that the Trust includes a domestic abuse ‘deep dive’ when they review whether their approaches to learning are effective.

3.103 This grading should be seen in relation to the actions associated with recommendations 1a, and 1c including the impact.

Recommendation 2

Number	Original Report Recommendation	Trust Action	Niche Grading
2	The CMHT, which now incorporates the assessment and brief intervention team, need to ensure that where it is known that patients under the care of that team are in a relationship that this is discussed in clinical reviews. Systems need to be put in place to identify and manage the potential risks when individual patients are thought to be in a potentially abusive relationship with another patient, this should include links with partner agencies.	Discussion at local quality meeting and senior management team, reminding staff to record this in the relationship status part of the clinical record. Potential risks and links with external agencies to be placed on the alert management system of JADE.	B

3.104 We asked staff about their understanding of the systems put in place to identify and manage potential risks when individual patients are thought to be in a potentially abusive relationship with another patient, including links with partner agencies.

3.105 Staff told us about and we viewed the electronic care records system alert and free text box for this information to be recorded, including the ability for two people to be linked if there is concern. Staff we spoke to were able to illustrate the use of this system with verbal examples.

3.106 We have graded this action as 'B' having been implemented and embedded in practice, however we have not been able to source information that would assist in assessing the impact of this.

3.107 The Trust needs to continue to seek formal assurance of the impact of this action and we recommend that the Trust addresses this through the QI workshops in CMHTs to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.

Recommendation 3

Number	Original Report Recommendation	Trust Action	Niche Grading
3	The CMHT should use the adults mental health initial assessment tool to collate information obtained from the patients, carers, family and other agencies at the point of referral to the service. Clinicians should use the tool as the basis for decision making and care planning.	Following service redesign the adult mental health initial assessment tool is now used as standard. Operational Policy will be updated to make this explicit.	D

3.108 To assess whether the adult mental health initial assessment tool is now used as standard and whether the Operational Policy had been updated to make this explicit, we viewed the Standard Operating Policy (SOP) for Hillingdon Adult CMHTs (implemented April 2016, for review February 2018) and noted that this Policy was out of date and required review. We were informed that this was in progress.

3.109 We found sections in the Policy on the referral process, assessment procedures and a separate section on assessments under the Mental Health Act 1983. The referral section asks staff to use a form entitled the MH1 initial assessment tool.

3.110 The assessment section states that comprehensive assessments of health and social care needs will be undertaken including consideration of physical health, family, housing, financial or occupational difficulties. Reference is made to using the initial assessment tool for all assessments followed by a core assessment if the patient is accepted into the service.

3.111 We found that the reference in the Policy to a MH1 form was out of date and should refer to a form entitled MH3. The MH3 is a mental health assessment form for all new referrals. It states that this form should be completed and emailed to the referrer, for example, the GP within 24 hours for an emergency or urgent referral or within five days for a routine referral.

3.112 The MH3 provides personal and referrer details, a formulation, a discussion of care, support and treatment options with the patient's views and goals, a care and crisis plan, physical health, a summary of care and support needs and full assessment details.

3.113 We were informed that compliance with MH3 was audited regularly and were provided with audit results (undated) which indicated that Hillingdon services were using an old assessment form and not the new the MH3 consistently, meaning that some assessment fields were not completed. As a result, compliance at month 6 (undated) was 49 percent. Team administrators were asked to recirculate the most up to date version of the form.

3.114 We viewed a Goodall Division Care Records Annual Audit 2017-2018 and found that, whilst this does not specifically refer to the MH3, elements of the MH3 had been audited. Care records contained a documented mental health care needs assessment in 83 percent of cases, and records showed evidence that external letters, for example to GPs, had been shared with the service user in 84 percent of cases. This particular audit also indicated that the initial assessment was followed by 94 percent of care plans being up to date and 93 percent had a care plan that reflected a current and detailed risk assessment.

3.115 We viewed the NWL commissioners Quality Schedule Contract Urgent Care Communication Standards MH3 for the period 1 April to 31 September 2018. As part of the quality schedule agreed with NWL commissioners, communication with primary care for patients referred as either emergency or urgent are reviewed every six months. As part of this review, the MH3 form has been audited by the Trust against an agreed set of standards

which include whether key information regarding patient care has been shared with GPs in a timely manner.

3.116 In total 10 cases were audited for compliance with 11 MH3 standards across each CCG under the NWL commissioning contract (from a mixture of routine, urgent and emergency referrals). Overall, 90 percent of mental health assessments were communicated to primary care through use of the MH3. In the cases where the MH3 form was not used, letters were used to communicate the outcome of the assessment to patients' GPs. Of the communications used to inform primary care of the patient's assessment, 72 percent were sent within the required timeframe. The auditing of MH forms will continue to be monitored quarterly by the Trust via the 2018-2019 NWL quality schedule.

3.117 In summary, we received assurance that the MH3 initial assessment was in use and being audited regularly by the Trust.

3.118 However, given that the SOP for Hillingdon Adult CMHTs is still under review and doesn't currently reflect the use of the MH3, we found that the internal investigation specific actions to update the Operational Policy and make this explicit had only been partially completed and graded this as 'D'.

3.119 We understand that the Trust went through major structural change in 2015-2016 and that through 2017 the systems were bedding down; however, we recommend that the SOP for Hillingdon Adult CMHTs is now updated within three months.

3.120 We found it difficult to assess the impact of this action, however, we examined patient feedback themes 2017-2018 and noted that communication between services, between staff, information getting lost, and not being passed on was still a concern.

3.121 We also noted that the Trust had highlighted a need to improve the quality of documentation. Their review found that while patient records contained necessary information, they often lacked sufficient details.

3.122 The Trust is taking the following actions to improve the quality of documentation:

- A QI project to help drive improvement in this area.
- Running workshops in CMHTs to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.
- Services will be required to develop service specific actions which will be subject to ongoing monitoring via divisional governance structures.
- Relevant staff to receive ongoing support via clinical and managerial supervision where any identified issues can be addressed individually or where applicable in groups.

3.123 The Trust needs to continue to seek formal assurance of the embeddedness and impact of this recommendation through the QI project structure.

Recommendation 4

Number	Original Report Recommendation	Trust action	Niche Grading
4	The CMHT should develop robust systems of communication with children and families social services wherever children are potentially at risk, in consultation with children and families social services.	A register of all service users who are subject to child protection procedures will be kept by each team in Hillingdon mental health services. Children's and family services will be asked to specify a mental health champion within the services as the direct point of contact.	E

3.124 The Trust told us that currently there is a lack of access to local child protection registers and that this is limited to a small number of services to maintain confidentiality. This does not currently include mental health services.

3.125 Staff told us that the alert function on the current electronic care record system allows for this information to be recorded but acknowledged that the action as specified had proved difficult to achieve. We were informed that the new electronic care records system (SystmOne) was currently being implemented covering the Trust community health services including health visitors and district nurses and that this would provide the ability to cross reference child and adult services and would mean improved access to this information via these sources.

3.126 We were told that domestic violence and impact on children templates have been developed for SystmOne and that further training is being launched in conjunction with the new system on recording children at risk.

3.127 We noted that the number of referrals from the Trust to Children's Social Care and Early Help had increased and the Trust safeguarding team had noted an increase in the number of calls for advice over the year, demonstrating both the complexity that staff are working with and that they are using the knowledge and skills learned in training to continually 'think family'[5] in their work.

3.128 We were informed that child safeguarding cases are discussed on a monthly basis in supervision. We looked at the Trust Clinical and Managerial Supervision Policy (approved November 2014, for review November 2017) and found a guidance section on child and adult protection supervision.

3.129 We viewed Hillingdon East and West CMHTs supervision template and anonymised supervision examples. We found that the template had a section on safeguarding adults and children. The anonymised examples included details of the safeguarding concerns and the action plan including liaison with social services, children's services and domestic abuse

[5] *The Think Family agenda recognises and promotes the importance of a whole-family approach family.*

services.

3.130 We were informed that the Children's Safeguarding Lead is currently facilitating Trust wide reflective group practice on the subject of safeguarding children co-facilitated with a member of staff from Children's Social Care and Early Help. However, a date has yet to be set for this to take place in Hillingdon East and West CMHTs.

3.131 We viewed an 11 September 2018 audit of psychiatric liaison safeguarding children information in the progress notes and found that the Psychiatric Liaison Team had identified service champions for safeguarding children within their team and subjected this key area to quarterly audit.

3.132 The audit examined whether there was a separate safeguarding children heading together with the appropriate information, to see if the interagency referral forms had been completed and whether this information was reflected in the progress notes.

3.133 The audit found that most assessments had a safeguarding heading in the progress notes following the assessment, however the information was not always recorded in such a way that would provide assurance that safeguarding children issues were explored during the assessment. The recommendation was that clinicians should consider writing 'no safeguarding children issues reported or identified' to show that this had been considered during the assessment.

3.134 We viewed a Goodall Division peer review June 2018 which specifically examined whether arrangements were in place to safeguard children from abuse and neglect, whether staff understood their responsibilities and adhered to safeguarding policies and procedures including working in partnership with other agencies, and whether staff identified children at risk of, or suffering significant harm. The peer review found notable practice in terms of supervision and staff understanding of safeguarding processes. No issues were identified or recommendations made.

3.135 We did not find Trust guidance on the peer review process; however, we understand this to be centred on the CQC five quality domains of safety, effectiveness, caring, responsive and well led services. The peer review recommendations and actions are overseen by the Division Quality Governance Team until they are closed.

3.136 Despite the actions the Trust, Hillingdon East and West CMHT and Psychiatric Liaison services have taken, we found the Trust acknowledged that that the specific action for the Hillingdon mental health services to keep a register of all service users subject to child protection procedures and to appoint a children's and family services mental health champion within the services as the direct point of contact has not been implemented.

3.137 We understand the difficulties associated with this are associated with a lack of access to local child protection registers and that this is limited to a small number of services to maintain confidentiality. This does not currently include mental health services.

3.138 We recommend that the Trust assess the risk and options to address this as

a matter of urgency Trust wide, and seek formal assurance of the completeness, the embeddedness and impact of this recommendation. We therefore graded this action as 'E' not completed.

Recommendation 5

Number	Original Report Recommendation	Trust Action	Niche Grading
5	Where risk is evident, the CMHT seniors or consultants must set out a formulation with a statement of what responsibility lies with the clinical team and what responsibility lies with the patient. These actions should be clearly documented in the patients care plan and disseminated to all involved including the patients care plan.	Discuss and remind at care quality meeting that the statement of responsibility must be clear in the 'NB' section of records and also documented in clinic letters and care plans.	B

3.139 To assess whether the statement of responsibility is made clear in the clinical documentation, we spoke to staff who told us that care plans written in the first person singular are accepted as best practice. We also viewed the Trust MH4 care plan review letter which contains a section for a personalised crisis plan, and the Trust MH5 transfer of care to GP letter which contains a recovery and stay well plan written in the first person singular. This plan included:

- Signs I am becoming unwell and risks.
- Plan when I am unwell.
- What recovery and staying well looks like for me.
- My recovery and stay well goals.
- Specifications and responsible person.
- Medication.
- Relevant physical health issues and investigations.

3.140 We viewed the NWL commissioners Quality Schedule Contract Urgent Care Communication Standards (use of, MH4 and MH5) for the period 1 April to 31 September 2018. As part of the quality schedule agreed with NWL commissioners, communication with primary care for patients referred as either emergency or urgent are reviewed every six months. As part of this review, MH4 (Care Plan Review) and MH5 (Transfer of Care to GPs) have been audited by the Trust against an agreed set of standards which include whether key information regarding patient care has been shared with GPs in a timely manner.

3.141 Ten cases were audited for compliance with MH4 standards across each

CCG under the NWL contract (from a mixture of routine, urgent and emergency referrals). Overall, 98 percent of care reviews were communicated to primary care through use of the MH4. In the one case where the MH4 form was not used, a letter from the team was used to communicate the outcome of the review to the patient's GP.

3.142 Ten cases were audited for compliance with MH5 standards across each CCG under the NWL contract. Overall, 90 percent of the transfers of care were communicated to primary care through use of the MH5. In the five cases in Hillingdon where the MH5 form was not used, letters from the team were used to communicate the outcome of the care plan to the patient's GP. The auditing of MH forms will continue to be monitored quarterly via the 2018-2019 NWL quality schedule.

3.143 We therefore found that the standard use of the MH4 and MH5 forms allowed both the statement of responsibility to be made clear and disseminated to all involved. We noted the Trust view that patients receiving a copy of their communication needed to be improved but we are satisfied that the review process will provide the ongoing assurance required in this area. We have therefore graded this action as 'B' implemented and embedded in practice.

3.144 We found it difficult to assess the impact of this action, however, we examined patient feedback themes 2017-2018 and noted that communication between services, between staff, information getting lost, and not being passed on was still a concern.

3.145 We noted that patients receiving a copy of their communication needed to be improved but are satisfied that the auditing of MH forms quarterly via the 2018-2019 NWL quality schedule will provide the ongoing assurance required in this area.

3.146 We also noted that the Trust had highlighted a need to improve the quality of documentation. Their review found that while patient records contained necessary information, they often lacked sufficient details. The Trust is taking the following actions to improve the quality of documentation:

- A QI project to help drive improvement in this area.
- Running workshops in CMHTs to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.
- Services will be required to develop service specific actions which will be subject to ongoing monitoring via divisional governance structures.
- Relevant staff to receive ongoing support via clinical and managerial supervision where any identified issues can be addressed individually or where applicable in groups.

3.147 The Trust needs to continue to seek formal assurance of the impact of this action and we recommend that the Trust addresses this through the QI workshops in CMHTs to support staff in all areas of clinical practice,

covering communication, risk, mental capacity, safeguarding and care delivery.

Recommendation 6

Number	Original Report Recommendation	Trust Action	Niche Grading
6	The CMHT must develop a system to ensure that clinical risk assessments are completed to the expected standard as per Policy for all patients.	A monthly peer review across all mental health teams with regard to the quality of risk assessments will commence.	B

3.148 To assess whether a monthly peer review across all mental health teams with regard to the quality of risk assessments commenced, we noted that risk assessments completed and linked to care plans was a Trust quality indicator for 2017-2018 carried over from 2016-2017 as the 95 percent target was not achieved.

3.149 The January 2018 CQC inspection report stated that a Trust workshop aimed at analysing issues affecting the quality of risk assessment was taking place in December 2017 and that progress was being reported to the Trust Quality and Performance Committee. Progress was reported as being slower than expected in the areas of risk assessment and care planning and we noted that both a performance and quality improvement approach was needed to deliver sustained improvements.

3.150 We note the Trust Quality Account 2017-18 states that the Trust is developing robust clinical risk assessments and safety plans in co-production with patients and carers as matter of priority. Work is underway to formulate a training package to refresh staff skills and knowledge in relation to risk and safety planning. In the meantime, the Trust is monitoring risk assessments and safety plans using existing performance systems including supervision and audits to make sure that any issues are identified and addressed in a timely manner.

3.151 We noted the related Trust Risk Assessment and Safety Planning Good Practice guidance (undated) designed to support clinicians in the formulation of risk assessments and safety plan documents.

3.152 We were informed by staff that the quality of risk assessments are monitored through the supervision process on an ongoing basis and learning needs are identified as required. We noted that the supervision template contained a section for care plan interventions and risk. A verbal example was provided of a member of staff identifying risk and not knowing what action to take. This was dealt with in supervision and escalated to the professional member of staff responsible for education and training.

3.153 We viewed the Trust care plan and risk assessment audit template and results for quarter two and three 2017-2018. We understand from staff that Team Managers are required to undertake this audit every two weeks sampling 20 cases per team. Compliance with this target in quarter three

2017-2018 was at 90 percent across the Trust, however performance in the Goodall Division was 100 percent.

3.154 We also viewed quarterly incidents and serious incidents reports which are developed in collaboration with the Divisions. These reports consider key themes, trends and outline key messages for the board regarding the most prevalent type of incidents, where actions to mitigate risks are a clinical priority for the Trust.

3.155 We noted that in quarter three 2017 - 2018, work to support Trust wide improvements in the application of the Clinical Risk Assessment & Risk Management Policy was underway across all adult CMHTs, complemented by a focused QI Project in the Brent CMHT, supported by the Safety Team, Clinical Education Team and the Imperial College Academic Health Science Network (AHSN).

3.156 A baseline of current clinical practice, systems and structures have been established and key interventions to enhance patient safety include the delivery of an evidenced based training programme to support staff to strengthen therapeutic relationships, identify key risks and protective factors and enhance decision making with patients and their carer's. A review of the Trust's Clinical Risk Assessment and Risk Management Policy, is underway which will be aligned with the new electronic SystmOne.

3.157 We viewed the June 2018 peer review for Hillingdon East and West to see whether comprehensive risk assessments were carried out, whether risk assessments management plans were developed in line with national guidance and risks managed positively. The peer review also looked at whether all the information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way including risk assessments. The peer review noted risk assessments and how to escalate concerns about risks as notable practice. There were no issues or recommendations made.

3.158 We did not find Trust guidance on the peer review process; however, we understand this to be centred on the CQC five quality domains of safety, effectiveness, caring, responsive and well led services. The peer review recommendations and actions are overseen by the Division Quality Governance Team until they are closed.

3.159 With regard to the specific action that there is a system in place to ensure that clinical risk assessments are completed to the expected standard as per Policy for all patients, we have graded this action as 'B' being completed and embedded in practice.

3.160 We are unable to assess the qualitative impact of this, given that the Trust is currently developing robust clinical risk assessments and safety plans in co-production with patients and carers as a quality priority.

3.161 The Trust needs to continue to seek formal assurance of the impact of this recommendation, and we recommend that this is included as part of the Trust wide improvements in the application of the Clinical Risk Assessment and Risk Management Policy.

Recommendation 7

Number	Original Report Recommendation	Trust Action	Niche Grading
7	The CMHT need to ensure that there is an effective system in place whereby patients who no longer require input from the team are closed on the patient electronic information system.	Administrative managers within teams will run monthly reports to establish activity within a four month period. This will identify closed cases on a monthly basis and the administrative manager along with the team manager will ensure these are closed from systems. Results from first run of the new system to be shared at senior management team.	B

3.162 We viewed a Hillingdon 2018 quarter two audit report, shared regularly with partners, and saw that this contained information on open cases, new cases, discharged cases, referrals into service and outcome, percentage of accepted referrals seen within 28 days, settled accommodation, employment for care programme approach patients, delayed transfers of care and placements.

3.163 To feed into this, the Team Administrator audits closed cases and no contact cases every month. We viewed the audit template.

3.164 We have therefore graded this action as ‘B’ being completed and embedded in practice.

3.165 We recommend that the Trust seeks formal assurance of the impact of this recommendation through the regular sharing of the Hillingdon quarterly report with partners, which contains information on open cases, new cases, discharged cases, referrals into service and outcome, and percentage of accepted referrals seen within 28 days.

Recommendation 8

Number	Original Report Recommendation	Trust Action	Niche Grading
8	The CMHT needs to review the role and responsibilities of the duty worker rota system to ensure that actions are always followed through, that updates are obtained and documented accurately.	Following recent community service redesign the duty system has been changed to reflect the need for continuity. This will be included in the Operational Policy for the teams.	D

3.166 We note from the Trust Hillingdon Services Annual Report 2016-2017 that there was a commitment in the plans for 2017-2018 to review the duty system to ensure it is robust and service users receive continuity of care.

3.167 Staff told us that the duty worker system developed over time, was not fit for purpose and has recently been reviewed. We viewed a duty worker actions guide (undated) developed as an interim measure to improve the tracking and management of duty items until a final procedure has been agreed.

3.168 This guidance outlines the duty worker responsibilities for the review of and triage of duty items and taking decisions on the action required and at specific times of the day. Relevant actions are collated on the following days duty action sheet or where appropriate and moved to other pathways, for example, to the multidisciplinary team for further discussion, to the HTT or to an urgent meeting.

3.169 We understand that the Trust went through major structural change in 2015-2016 and that through 2017 the systems were bedding down; however, we recommend that a task group approach is taken to the implementation of the final duty system within a three month timescale, with formal assurance provided of the completeness, embeddedness and impact of this action.

3.170 We have therefore graded this action as ‘D’ being partially completed.

Recommendation 9

Number	Original Report Recommendation	Trust Action	Niche Grading
9	CNWL medicines management group to ensure that all prescribers within the Trust are made aware of the Policy in relation to off-licence prescribing.	CNWL medicines management group will send a memo reminding prescribers of the Policy.	C

3.171 We viewed the Trust annual medicines optimisation report to the Board for 2017/18 report. This report provides assurance on the use of medicines within the Trust. It reviews medicines activity and also highlights the work programme for 2018 onwards.

3.172 The report detailed that the 2017 CQC mental health community patient survey rated medications ‘as expected’. A significant rise in patient helpline

calls is noted, indicating increasing awareness of the medicine resources available. There were 1,955 medication incidents reported on DATIX in 2017-2018 with less than 1 percent rated as moderate or severe harm. There were no serious patient related medication incidents.

3.173 We viewed a June 2016 Medicines Management Group Newsletter with a section entitled 'Prescribing off label'. The newsletter states that the Medicines Management Group meeting minutes are added to the Trust Intranet and this is signposted in the weekly news bulletin together with a contact point for any questions.

3.174 The 'Prescribing off label' section reminds prescribers that if they prescribe a UK licenced medicine outside of the relevant license, for example, for a different indication or for a different patient group, then this constitutes 'off label' prescribing and carries with it considerable personal responsibility for the prescriber.

3.175 The section states that the manufacturer carries no legal liability for unlicensed medicines or 'off label' use of medicines unless harm results from a defect in the product and reminds prescribers that they should discuss any 'off label' prescribing with the patient and document this in the patient's clinical records.

3.176 Staff are signposted to a Trust Policy entitled 'Unlicensed medicines' and 'off label' use' (approved June 2018, for review June 2021). The Policy was first created in 2002 and has had a routine two-yearly review with a narrative to describe the changes.

3.177 The Policy indicates that the Policy is essential reading for all prescribers, all nurses, pharmacy staff, managers of services where medicines are prescribed, supplied or administered and all staff caring for patients treated with medicines.

3.178 The Policy includes the General Medical Council (GMC), the General Pharmaceutical Council (GPhC) and the Nursing and Midwifery (NMC) guidance on prescribing unlicensed medicines.

3.179 The Policy states that the Chief Pharmacist is responsible for the governance of unlicensed medicines and ensures that systems are in place to monitor and manage risks associated with the use of off-licence medicines. This includes a flow chart for requesting and approving an unlicensed medicine including an application form, a technical and clinical risk assessment tool and monitoring forms for dispensing and administering unlicensed medicines.

3.180 We viewed the patient information leaflet, which is also attached to the 'Unlicensed medicines' and 'off label' Policy. This leaflet clearly sets out what an unlicensed medicine is, why it may be considered for use, how it would be monitored, and the right of the patient to decline the treatment.

3.181 We were informed that the Trust do not routinely audit 'off label' prescribing unless there is a specific requirement, for example, with the prescribing of high dose antipsychotic medicines, or where pharmacy staff have reviewed quarterly patient safety incidents and find a safety issue that requires audit.

We viewed several Trust and national audits of high dose antipsychotic medication.

3.182 It is clear therefore that this action has been implemented, that the appropriate governance systems are in place to ensure that the practice is embedded, and there is audit to support this. We have therefore graded this as 'C' as being implemented.

3.183 However, the internal investigation found that the 'Unlicensed medicines' and 'off label' use' Policy was not being adhered to specifically with regards to the use of off-licence prescribing in personality disorder. We therefore recommend that this is subjected to audit by the Trust to seek formal assurance of the specific embeddedness and impact of this action.

Recommendation 10

Number	Original Report Recommendation	Trust Action	Niche Grading
10	The CMHT should ensure that where there is significant forensic history, including claims of a serious criminal nature of patients who come into contact with mental health services when a patient is known to MAPPA, there should be clear evidence of liaison by mental health services within this body.	Information received from MAPPA, relevant to current service users will be discussed at daily zoning meetings within the services.	E

3.184 We examined the Trust review of the Policy for the Multi-Agency Public Protection Arrangements (MAPPA) to seek assurance that there is appropriate support and guidance for staff in this area. The MAPPA Policy review is being undertaken due to the national guidance changing. The draft Policy is undated but clearly states that in order to effectively manage and contain identified risk, the Trust will have clear lines of management and accountability for MAPPA processes in place in order that effective lines of information sharing and risk assessments take place. We were informed that the Trust Divisional Managers will ensure compliance with this Policy.

3.185 The Policy states that the first stages of the process for the Trust are to identify offenders who may be liable to management under MAPPA as a consequence of their caution or conviction and sentence, and later to notify the MAPPA coordinator of their impending release into the community, or the commencement of a community order or suspended sentence, as appropriate. This responsibility falls to the agency that has the leading statutory responsibility for each offender.

3.186 Once a patient is hospitalised through a criminal justice route, they should be identified as a MAPPA case by mental health services including private and independent sector providers. A formal notification to the relevant MAPPA coordinator for the local area of the patient's home address should be made, using the MAPPA I form at the point of admission to hospital.

3.187 The Policy states that a full referral is not required at this stage. Early

notification serves to support mental health service providers' awareness of MAPPA, the identification of MAPPA offenders as required by legislation, and the tracking of MAPPA patients.

3.188 Notification should occur throughout the care pathway and the MAPPA I form should be updated further at key points in the patient's treatment to ensure a continuing dialogue between the Trust and the responsible MAPPA area, including first unescorted leave, discharge and exit from MAPPA. It may also be appropriate to complete the MAPPA I for first escorted leave if there is an identified risk of absconding.

3.189 The Policy clarifies that as forensic patients may be in regional units away from their home areas and initial leave may be in a different MAPPA locality from the final discharge area, multiple MAPPA areas may be involved and communication between areas is expected, together with the local police. The process for this would be led by the secure hospital or unit where the service user is an inpatient who would make the referral to the home MAPPA.

3.190 If the Trust is aware that a patient admitted through a civil route is a MAPPA-managed offender, they should contact the lead agency if known, or otherwise the local MAPPA co-ordination unit. If a patient admitted through a civil route is displaying worrying behaviour and the clinician is concerned about a possible risk to the public, they should obtain a Police National Computer (PNC) check through their police liaison lead who can confirm whether the patient is a MAPPA offender or has any previous convictions that suggest they may need MAPPA management.

3.191 The Policy is clear that the Trust will attend 90 percent of appropriate MAPPA meetings in the Trust areas and meet the general duty to co-operate as a core panel member with continuity of personnel in order to sustain good working relationships. The Trust describes a core panel member as having a level of seniority and the authority to commit resources on behalf of the Trust and should possess relevant experience of risk and needs assessment, as well as analytical and team-working skills.

3.192 If the core member does not have direct knowledge of the MAPPA case under discussion a representative(s) of the patient's clinical team should also be invited to attend to contribute to the MAPPA discussion on individual cases. This is likely to be the care co-ordinator and, or the Responsible Clinician or a suitable alternative who will be expected to be well-briefed on the issues relating to the particular case.

3.193 The Trust plan to monitor all MAPPA cases centrally by the Trust which will be captured on the clinical system, and prior to the development of the electronic solution, this will be managed by a manual database held by the Mental Health Act Administration Team.

3.194 The Trust provides statistics to the London MAPPA Strategic Management Board (SMB) on the number of managed MAPPA patients and these figures are published in the London SMB MAPPA Annual Report. The Criminal Justice Act 2003 requires each area to publish information annually on the operation of MAPPA at the local level. This complies with the national

requirements and maintains public confidence in the system.

3.195 Staff were able to articulate the MAPPA process and told us that the Safeguarding Manager for the London Borough of Hillingdon represents the Trust at the Hillingdon MAPPA meetings together with the care coordinator or the Responsible Clinician as required.

3.196 In addition to assessing Trust guidance, we spoke to staff in the Hillingdon East and West CMHT who confirmed that the guidance is available for staff on the shared electronic drive, that there is a police liaison officer attached to the services, and that MAPPA patients are discussed in the daily zoning meetings. However, specific assurance in the form of meeting notes was not received.

3.197 We have therefore graded this action as 'E' as there is not enough evidence to say that this is completed.

3.198 We recommend that the Trust seeks formal assurance of the completeness, embeddedness and impact of this action within three months, through auditing the daily zoning meeting notes, and by ratifying the draft MAPPA Policy. The schedule for monitoring compliance through Trust Divisional Managers must be clear within the Policy.

Recommendation 11

Number	Original Report Recommendation	Trust Action	Niche Grading
11	The CMHT should ensure that patient discharge information is sent to all relevant professional teams and services.	Communication reminding staff of the need to ensure that the patient discharge communication is sent to all relevant professionals, teams and services will be sent to all staff. Discharge communication is sent using and MH5 form. An audit will take place to ensure that all relevant parties have been copied into this.	B

3.199 This action also relates to the recommendation and action number 5.

3.200 To assess whether the statement of responsibility is made clear in the clinical documentation, we spoke to staff who told us that care plans written in the first person singular are accepted as best and normal practice. We also viewed the Trust MH5 discharge and transfer of care to GP letter which contains a recovery and stay well plan written in the first person singular. This plan included:

- Signs I am becoming unwell and risks.
- Plan when I am unwell.
- What recovery and staying well looks like for me.

- My recovery and stay well goals.
- Specifications and responsible person.
- Medication.
- Relevant physical health issues and investigations.

3.201 We viewed the NWL commissioners Quality Schedule Contract Urgent Care Communication Standards (use of MH5) for the period 1 April to 31 September 2018. As part of the quality schedule agreed with NWL commissioners, communication with primary care for patients referred as either emergency or urgent are reviewed every six months. As part of this review MH5 (Transfer of Care to GPs) have been audited by the Trust against an agreed set of standards which include whether key information regarding patient care has been shared with GPs in a timely manner.

3.202 Ten cases were audited for compliance with MH5 standards across each CCG under the NWL commissioning contract. Overall, 90 percent of the transfers of care were communicated to primary care through use of the MH5. In the five cases in Hillingdon where the MH5 form was not used, letters from the team were used to communicate the outcome of the care plan to the patient's GP. The auditing of MH forms will continue to be monitored quarterly via the 2018-2019 NWL quality schedule.

3.203 We therefore found that the MH5 form allowed the patient discharge communication to be disseminated to all involved. We found it hard to assess the impact of this action, however, we examined patient feedback themes 2017-2018 and noted that communication between services, between staff, information getting lost, and not being passed on was still a concern.

3.204 We noted that patients receiving a copy of their communication needed to be improved but are satisfied that the 2018-2019 NWL quality schedule will provide the ongoing assurance required in this area.

3.205 We also noted that the Trust had highlighted a need to improve the quality of documentation. Their review found that while patient records contained necessary information, they often lacked sufficient details. The Trust is taking the following actions to improve the quality of documentation:

- A QI project to help drive improvement in this area.
- Running workshops in CMHTs to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.
- Services will be required to develop service specific actions which will be subject to ongoing monitoring via divisional governance structures.
- Relevant staff to receive ongoing support via clinical and managerial supervision where any identified issues can be addressed individually or where applicable in groups.

3.206 We have therefore graded this as ‘B’ implemented and embedded in practice.

3.207 We recommend that the Trust seeks assurance as to the impact of this action through the QI project to help drive improvement in this area.

Recommendation 12

Number	Original Report Recommendation	Trust Action	Niche Grading
12	The CMHT should ensure that the practice of making clinical entries and sending written communication regarding outcomes of clinical reviews should be completed.	Communication reminding staff of the need to ensure that the practice of making clinical entries and sending written communication regarding outcomes of clinical reviews should be completed and sent to all staff. A randomised audit will take place specifically looking at the timeliness of entries.	B

3.208 We understand from staff and saw in the Trust Hillingdon Services Annual Report 2016-2017 that in February 2016 the Hillingdon CMHTs were redesigned with the creation of three new teams. GP catchment areas were reviewed resulting in approximately two thirds of the client caseload changing to better align with staff capacity. The focus in 2016 was the development of processes for those new services and settling into new teams and ways of working, with a large change in client caseloads and a huge amount of work to improve the accuracy of the caseload.

3.209 Staff told us that these previous team structures meant that the practice of making clinical entries and sending written communication regarding outcomes of clinical reviews was hindered due to the clinical workload being excessive. Staff told us that this is now resolved with the new team structures and has not recently been identified as a concern.

3.210 We viewed a clinical record keeping and consent audit 2015–2016 which showed that within the Goodall Division mental health services good compliance was found with five of the eight criteria measured including NHS number recording, records in chronological order, timely and contemporaneous entries, legibility of scanned images and sharing letters with patients.

3.211 We also viewed the Trust Information Governance Toolkit (IGT) achievement for 2017–2018. Every year the Trust is required to complete a major audit of its information governance status measured against a range of 45 requirements set by the Department of Health covering information security, legal compliance, data quality and information management. Completion of the IGT is a requirement for all Health and Social Care service providers and is an important quality benchmark.

3.212 In particular, we noted that the IGT confirmed that procedures are in place to ensure the accuracy of service user information on all systems and, or records that support the provision of care, and that a multi-professional audit of clinical records across all specialties had been undertaken. The 2017-2018 Trust Information Governance Toolkit was submitted to the Department of Health on 27 March 2018 with an overall score of 86 percent and rated as satisfactory.

3.213 We also noted from the Trust Quality Account 2017–2018 that the Trust Business Intelligence Tool Tableau was rolled out with full implementation and went live in April 2017. This has improved staff access to data and provides analysis in a clear and user-friendly format. Reports are available on Tableau that highlight areas where there are issues with data quality, and this has enabled staff to more easily identify and address any issues. Data quality is monitored at all levels of the Trust, including Trust Board, the Quality and Performance Committee, Divisional Board, local Senior Management team meetings, Care Quality team meetings as well as staff supervision sessions.

3.214 Business rules for all indicators are published and are available to staff members on the Trust intranet. Divisional performance teams work closely with clinical services to improve data quality. This includes increased scrutiny and analysis of areas, and targeted training for teams and staff members.

3.215 We have therefore graded this action as 'B' being completed and embedded in practice. The Trust needs to continue to seek formal assurance of the impact of this action through the Trust Business Intelligence Tool Tableau governance structure.

Recommendation 13

Number	Original Report Recommendation	Trust Action	Niche Grading
13	The Hillingdon mental health services should ensure that all staff are made aware of the access criteria to their respective teams.	To ensure access criteria is included in the Operational Policy.	D

3.216 To assess whether the access criteria tool is included in the operational Policy we viewed the Standard Operating Policy (SOP) for Hillingdon Adult CMHTs (implemented April 2016, for review February 2018) and noted that this Policy was out of date and required review. We were informed that this was in progress.

3.217 We found a section in the Policy on entry criteria and the circumstances and symptoms associated with significant risk. We spoke to staff and found that they were clear on the access criteria.

3.218 We understand that the Trust went through major structural change in 2015-2016 and that through 2017 the systems were bedding down; however, we recommend that the SOP for Hillingdon Adult CMHTs is now updated within three months. We have therefore graded this as 'D' given the SOP is

currently under review and recommend that this is completed within three months.

3.219 We note that the Hillingdon September 2018 quarterly report, shared regularly with partners, contained information on open cases, new cases, discharged cases, referrals into service and outcome, and percentage of accepted referrals seen within 28 days.

3.220 We are therefore assured from this process that any concerns about access would be highlighted and action taken providing assurance of the embeddedness and impact of this action and have no further recommendations to make.

4 Summary

4.1 It is acknowledged that this homicide has had far reaching effects on the Trust. Due to the major structural change within the Trust commencing in 2015 when this incident occurred, through to 2016-2017 as new services bedded down, we found it difficult to assess the assurance against the local actions very specifically, as structures and systems have changed considerably.

4.2 We have therefore assessed assurance as far as possible within the local Hillingdon mental health services where applicable and have provided further information about Trust assurance systems which have been put in place since then.

4.3 We found that the assurance for action 1b was subsumed in actions 1c and 1d.

4.4 In terms of the two fixed recommendations, the 15 remaining original report recommendations and associated Trust actions, we have summarised the Niche grading totals as follows:

Grade	Niche Criteria	Number
A	Evidence of completeness, embeddedness and impact.	1
B	Evidence of completeness and embeddedness.	7
C	Evidence of completeness.	4
D	Partially complete.	3
E	Not enough evidence to say complete.	2
	Total number of actions	17

4.5 Where the action resulted in a grading of B, C, D or E we have made residual recommendations for the Trust to seek formal assurance of the completeness, embeddedness and impact against each action as appropriate.

4.6 We have made residual recommendations in respect of one of the fixed and the DHR recommendation.

4.7 In respect of Trust action 13, we have not made a residual recommendation as we are assured that the Hillingdon September 2018 quarterly partnership report would highlight and enable action to be taken with access concerns.

Residual recommendations

Fixed recommendation

4.8 With reference to the fixed recommendation to share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams/services as applicable for the purposes of learning, we found it difficult to assess the specific impact of this fixed recommendation, as domestic abuse has not featured as a theme in Trust serious incidents, and the learning associated with this has therefore not been scrutinised.

4.9 We recommend therefore that the Trust includes a domestic abuse 'deep dive' when they review whether their approaches to learning are effective.

DHR recommendation

4.10 In terms of the Trust action in respect of the DHR recommendation, that the Trust 'Domestic Abuse Policy and Guidance' should contain guidance on the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client, we did not find the appropriate assurance to meet the DHR recommendation. We recommend that in the interim a clinical message of the week is utilised to advise staff accordingly until an amendment to the Policy can be actioned.

Trust action 1a, 1c and 1d

4.11 We recommend that the Trust includes a domestic abuse 'deep dive' when they review whether their approaches to learning are effective, to seek formal assurance of the embeddedness and impact of these actions.

Trust action 2

4.12 We recommend that the Trust seeks formal assurance of the impact of this action through the QI workshops in CMHTs to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.

Trust action 3

4.13 We recommend that the Trust seeks formal assurance of the embeddedness and impact of this recommendation through the QI project structure to improve the quality of clinical documentation, to ensure the initial assessment tool is being used as the basis for decision making.

Trust action 4

4.14 We recommend that, as a matter of urgency, the Trust assess the risk and develop Trust wide options to address the specific action for the Hillingdon mental health services to keep a register of all service users subject to child protection procedures and to appoint a children's and family services mental health champion within the services as the direct point of contact.

Trust action 5

4.15 We recommend that the Trust seeks formal assurance of the impact of this action through the QI workshops in CMHTs to support staff in all areas of clinical practice, covering communication, risk, mental capacity, safeguarding and care delivery.

Trust action 6

4.16 We recommend that the Trust seeks formal assurance of the impact of this recommendation, through the Trust wide improvements in the application of the Clinical Risk Assessment and Risk Management Policy.

Trust action 7

4.17 We recommend that the Trust seeks formal assurance of the impact of this recommendation through the regular sharing of the Hillingdon quarterly report with partners, which contains information on open cases, new cases, discharged cases, referrals into service and outcome and percentage of accepted referrals seen within 28 days.

Trust action 8

4.18 We recommend that a task group approach is taken to the implementation of the final duty system within a three month timescale, with formal assurance provided of the completeness, embeddedness and impact of this action.

Trust action 9

4.19 We recommend that the 'Unlicensed medicines' and 'off label' use' Policy specifically with regards to the use of off-licence prescribing in personality disorder is subjected to audit by the Trust to seek formal assurance of the embeddedness and impact of this action.

Trust action 10

4.20 We recommend that the Trust seeks formal assurance of the completeness, embeddedness and impact of this action within three months, through auditing the daily zoning meeting notes, and by ratifying the draft MAPPA Policy including monitoring compliance.

Trust action 11

4.21 We recommend that the Trust seek assurance as to the impact of this action through the 2018-2019 NWL quality schedule.

Trust action 12

4.22 We recommend that the Trust seeks formal assurance of the impact of this action through the Trust Business Intelligence Tool Tableau governance structure.

Appendix A - Terms of reference

Purpose of the Review

To independently review the progress and implementation of actions by the Trust from the internal investigation into the care and treatment of service user A and service user B, the Domestic Homicide Review and the embedding of learning across the Trust and identify any other areas of learning for the Trust and/or CCG. The outcome of this review will be managed through governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

Terms of Reference

Review the implementation of the Trust's internal investigation action plan and identify:

- Review progress made against the action plan.
- Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.
- Comment on the CCG monitoring of action plan.
- Make further recommendation for improvement as appropriate.

Review the Trusts actions following the Domestic Homicide Review and processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

Timescale

The review process starts when the investigator receives the Trust documents and the review should be completed within 6 months thereafter.

Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.
- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

Outputs

A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

At the end of the review, to share the report with the Trust and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.

A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

We will require monthly updates and where required, these to be shared with families, CCGs and Providers.

The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate.

Appendix B – People Interviewed

Designation	Date
Head of Serious Incidents Investigation Team	13 September 2018
Hillingdon Borough Director	11 October 2018
Hillingdon Deputy Borough Director	11 October 2018
Assistant Director of Quality and Safety NHS Harrow CCG	17 October 2018
Associate Director of Quality, Safeguarding and Safety and Security	23 October 2018
Associate Director for Quality Assurance, Improvement and Involvement	23 October 2018
Hillingdon East CMHT Team Manager	7 November 2018
Hillingdon East and West CMHT Office Manager	7 November 2018
Hillingdon Team Manager West CMHT and Community Rehabilitation	7 November 2018
Hillingdon Approved Mental Health Professional Social Work Team Manager East CMHT	7 November 2018
Safeguarding Lead	Telephone 15 December 2018
Divisional Head of Quality Governance Goodall	20 December 2018
Borough Lead Pharmacist	15 January 2019
Trust Safeguarding Children Advisor, Mental Health and Child and Adolescent Mental Health Services (CAMHS).	16 January 2019

Appendix C – Documents reviewed

	Document	Date
1	Domestic Homicide Review 'Lottie"	March 2015
2	CNWL Panel of Inquiry Internal Investigation Report	15 April 2016
3	CNWL Action Plan	Undated
4	IDVA criteria for agency referral and referral form	N/A
5	Email from CNWL Safeguarding Lead	5 May 2017
6	Email from CNWL Interim Inpatient and Acute Service Manager	12 April 2016
7	Email from Standing Together Mental Health Coordinator	6 July 2017
8	Email from Borough Lead Pharmacist	15 June 2016
9	Medicines Management Group newsletters	June and November 2016
10	Deafhope specialist support	N/A
11	Domestic abuse leaflet	N/A
12	Domestic violence outreach service	N/A
13	Coffee Mornings	N/A
14	Domestic violence posters	N/A
15	Domestic violence training information	N/A
16	Safeguarding information for teams	N/A
17	MH3 Mental Health Assessment form	N/A
18	MH4 Care Plan review letter	N/A
19	MH5 Transfer of Care to GP letter	N/A
20	East and West CMHT Risk Assessment audit template	N/A
21	Quarter 1 CMHT East and West peer review	June 2018
22	Anonymised example of a care planning meeting	N/A
23	Phase 2 Community Care Pathway meeting minutes	22 February 2018
24	Goodall Division Care Records Audit report	19 March 2018
25	Quarter 2 Hillingdon Community Quality Metrics Audit	2017-2018
26	Section 75 Report Quarter 2	September 2018
27	Domestic Abuse Learning Event poster	29 November 2018
28	Organisational Learning Highlight report	12 July 2018
29	Serious Incident Review poster	January 2017
30	Thematic Review poster	2015-2016
31	Cross Organisational Learning	2016-2017
32	Hillingdon Care Quality Group minutes	11 August 2016

33	Duty Senior Actions	Undated
34	Anonymised supervision examples	N/A
35	East and West CMHT Business Meeting minutes	29 September 2018
36	Clinical Record Keeping Audit report	2015-2016
37	Clinical and Managerial Supervision Policy	November 2014 (review November 2017)
38	Domestic Abuse Policy and Guidance	August 2017 (review August 2020)
39	Learning and Improvement guide	Version 9 July 2015
40	Standard Operating Policy for Hillingdon Adult CMHTs	18 March 2016 (review February 2018)
41	Unlicensed Medicines and Off Label use of Medicines Policy	June 2018 (review June 2021)
42	NWL Quality Schedule Contract. Urgent Care Communication Standards (use of MH2, MH3, MH4 and MH5)	31 October 2018
43	Goodall Division Serious Incident Management Process	July 2018
44	Goodall Division Duty of Candour Standard Operating Procedure	January 2018
45	Responding to and Learning from Deaths Policy	September 2017
46	Care Quality Commission Quality Report	August 2017
47	High Dose Antipsychotic Therapy within Mental Health Rehabilitation	December 2017
48	POMH-UK Prescribing High Dose and Combined Antipsychotics	September 2017
49	Trust Board papers	January – November 2018
50	Trust Hillingdon Services Annual report	2016-2017
51	Trust Annual Report and Quality Account	2017-2018

Appendix D – Hillingdon Community Mental Health Services

Hillingdon CMHT East and West

Hillingdon Mental Health has three CMHTs, each of which services a group of GP practices, looking after patients within those practices that require input from Community Mental Health Services.

All teams are multidisciplinary, consisting of medical staff, nursing staff, social work staff, occupational therapy, psychology, employment specialists, support workers, peer support workers and administration staff.

Teams operate Monday to Friday 9am–5pm. The teams see a range of clients within the service, generally over the age of 18 years. There is no upper age limit as transfer into our Older Adults Services is dictated now by vulnerability as opposed to age. The teams see people for new assessments, short term work and longer-term work either under Care Programme Approach (where patients are assigned a care coordinator to support them) or Lead Professional Care. The remit is within the domain of Severe and Enduring Mental Illness and teams can also see and signpost people with a mild degree of Mental Ill Health.

The goal is to enable people to recover and live meaningful lives with their mental disorder and patients are encouraged to attend groups at the Recovery College.

Teams are a dual Health and Social Care Service and assessments and subsequent care planning adopt this dual approach, to incorporate the Care Act 2014. As well as case work we also offer a duty service for support, guidance and assessment within our working hours.

Each team has a caseload of approximately 600 - 700 patients.

The Assessment and Brief Intervention team (ABT)

For clarity, the Trust describe the ABT as sitting at the beginning of the care pathway, providing mental health and clinical risk assessment, referral and sign posting to other services. This includes both referral along the secondary care pathway and referral to those agencies and services that sit in primary care, including those provided by the non-statutory sector.

The nature of the ABT role is such that it provides assessment for a large number of patients referred to them from a wide range of sources (e.g. GPs, emergency duty teams, housing, social services). It is standard practice for ABTs to offer patients a limited number of sessions in order to assess the nature of the mental health need prior to referring on or discharging back to Primary Care. The ABT consultants, speciality doctors, and nursing and occupational therapy staff provide assessment and review but do not support patients in the longer term.

Patients under the care of the ABT are supported within the remit of lead professional care. Whilst the ABT doctors have caseloads of patients, the other multi-disciplinary team members are allocated patients through use of a duty and task system. Therefore, there is less opportunity to develop a rapport and knowledge of the patient over a period of time. Patients referred to the ABT may be in contact with several different professionals in the team resulting in not having a consistent professional relationship.