December 2020

Independent review of the progress and implementation of the actions arising from the Trust RCA investigation into the care and treatment of Mr S provided by Central North West London NHS Foundation Trust

MAZARS

Introduction

Mr S was a service user at Central and North West London NHS Foundation Trust (CNWL - 'the Trust') who was first referred to Services in August 2013 when he was admitted under Section 2 of the Mental Health Act (MHA). He was diagnosed with paranoid schizophrenia. Mr S was an inpatient until he was transferred to the Colham Green Rehabilitation Unit in December 2014. He remained at the Unit until he was discharged to the care of the Early Intervention Service (EIS) in March 2015.

Mr S used inpatient and community services from March 2015 onwards. He had accommodation in a shared flat provided by Hestia Housing. Mr S shared the accommodation with Ms A, a woman he did not know prior to moving in. He started to report difficulties with Ms A to trust staff in April 2015. Mr S was admitted to an inpatient ward in at the end of July 2015, where he remained for nearly a month, until he was discharged on 24 August 2015 for continued cannabis use. Mr S was under the care of the home treatment team and early intervention service after his discharge.

Mr S attended the Urgent Care Centre on the night of 10 November 2015 asking to be admitted to a ward. Mr S was assessed by two Psychiatric Liaison nurses who concluded he did not need to be admitted. Mr S became abusive and was escorted from the Trust site by security. Mr S attended the Urgent Care Centre again in the early hours of 11 November 2015, asking to be admitted. Mr S' mental state was noted to have not changed since the earlier assessment. He was told that his plan had not changed and a bed was not available, at which point Mr S became abusive and left the site.

Ms A was found dead at home on 11 November 2015. Mr S was arrested and charged with Ms A's death on 13 November 2015. He pleaded guilty to manslaughter on the grounds of diminished responsibility on 19 December 2016. He was detained indefinitely under Section 37 and 41 of the Mental Health Act.

Further details of Mr S' care can be found in the chronology.

The Trust completed its internal investigation into Mr S' care and treatment on 4 August 2017. The investigation report included an action plan with nine recommendations, all of which were scheduled for completion between September and December 2017.

Mazars was commissioned in June 2018 to undertake an assurance review into the Trust's progress with its action plan.

Senior CNWL Hillingdon staff informed NHS England and Mazars at the review start-up meeting in August 2018 that the London Borough of Hillingdon (LBH) had undertaken a 'Safeguarding Adults Review' (SAR), commissioned independently and completed by an independent consultant. The Trust shared the report with NHSE and Mazars once LBH confirmed the report had been signed off and therefore, in the public domain.

Terms of reference

The purpose of the review was:

"*To independently review clinical notes primarily on 10th and 11th November 2015, the progress and implementation of actions by the Trust from the internal investigation into the care and treatment of* [Mr S] *and the embedding of learning across the Trust and identify any other areas of learning for the Trust and/or CCG"*

The terms of reference - drafted by NHS England (NHSE) - were:

- *Review of clinical notes in relation to the assessment and risk management in Accident and Emergency on 10th and 11th November 2015.*
- *Review the bed management processes during November 2015 and the current practice for bed management[1].*
- *Review the housing management/allocation process and communication with Mental Health services and clarification of responsibilities.*
- *Review progress made against the Trust's internal investigation 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.*

[1] Please note that following a meeting with NHSE and the Trust in September 2018 it was agreed that focus should be on current bed management processes as opposed to those in place in 2015 which have since changed.

Our approach

Mazars health and Social Care Advisory team is a multi-disciplinary team that provides specialist independent advisory support to health and social care commissioners and providers. Mary-Ann Bruce, Director, oversaw this review. Kathryn Hyde-Bales, Manager, was the lead reviewer. Geoff Brennan, Registered Mental Health Nurse and Learning Disabilities Nurse (RMHN and LDN) provided mental health nursing input.

We undertook interviews with eight members of Trust staff and the CCG. A list of interviewees can be seen in Appendix A. We attended a Hillingdon bed management meeting in November 2018.

We undertook a focus group with five members of the community teams and Early Intervention Service (EIS) in January 2019. Representatives from the HTT and inpatient ward were invited, but were unable to attend at short notice. We met with staff at Colham Green Rehabilitation Unit the same day.

We submitted information requests to the Trust and Harrow Clinical Commissioning Group (CCG). A list of the documents review can be seen in Appendix B.

We would like to thank all those involved for taking part in the interviews, meetings and focus groups for their time and input, and for providing follow-up information as requested.

We undertook a joint visit with NHSE to meet Mr S in October 2018 however he declined to see us on the day. NHSE tried to contact Mr S' mother, with a view to us meeting her jointly, however she did not respond to NHSE's request to meet. NHSE tried to contact Ms A's family but did not receive a response.

We submitted the draft report to the Trust for factual accuracy checking and comment. We shared a copy of the draft report with Mr S via his responsible clinician. We shared the draft section of the report pertaining to the CCG with the CCG.

We submitted our final report to NHSE England in June 2019.

Brief Chronology

The purpose of the review is to consider the Trust's investigation into the care and treatment of Mr S and the Trust's progress in implementing its action plan. Although we have considered the clinical notes relating to the assessment on 10th and 11th November 2015, and the bed management processes during November 2015, this is not a review of Mr S' care and treatment. However, for context we set out a brief summary of Mr S' care between August 2013 and November 2015 when he was a service user at the Trust.

Mr S was first referred to Hillingdon Mental Health Services in August 2013 when he was admitted to Frays Ward[2] at Hillingdon Riverside Mental Health Unit under Section 2 of the Mental Health Act (MHA). He was diagnosed with paranoid schizophrenia.

Mr S remained on Frays Ward until he was transferred to Colham Green Rehabilitation Unit in December 2014. He remained at the Unit until he was discharged to the care of the Early Intervention Service (EIS) in March 2015. Mr S had a care coordinator and was under the Care Programme Approach (CPA).

Mr S had a room in a shared flat provided by Hestia Housing. Hestia Housing was a housing provider commissioned by LBH to provide accommodation for individuals with housing needs. Ms A (aged 50 at the time of the incident) also lived at the address. Mr S and Ms A did not know each other prior to being housed together. Mr S started to report difficulties with Ms A to Trust staff in April 2015. In May 2015 a supporter worker reported to the Trust that Mr S might not be consistently taking his medication.

Mr S was taken to hospital on 31 July 2015 experiencing psychotic symptoms. He had a stab wound that he later told the police was self-inflicted. Mr S was admitted to Frays ward. During his admission, Mr S voiced frustrations about Ms A who he said controlled the hot water in the flat, locked him out of the home at night and stole his food.

Mr S smoked cannabis on the ward. He was warned by ward staff that he would be discharged if he continued to smoke on the ward, however he continued, and was discharged to the Home Treatment Team (HTT) on 24 August 2015.

Mr S was spoken to by members of the HTT and EIS between 24 August and 10 November 2015. Staff also attended Mr S' home routinely for scheduled appointments, but he was usually not home.

Mr S was seen by his EIS Care Coordinator and student nurse on 8 September and 5 October 2015. He denied any thoughts of self-harm or harm to others. During the visit on 5 October, Mr S expressed some paranoid thoughts and was noted by visiting community staff to have a large knife on his bedroom floor. Mr S said he had the knife to keep himself safe – his Care Coordinator encouraged him to put the knife away. Mr S' Care Coordinator noted that Mr S was on the wrong medication[3]. Mr S' medication was meant to be 15mg Aripiprazole but this had run out a few days before so he had reverted to taking a previous prescription of 4mg Risperidone. Mr S told his Care Coordinator that he would go to his GP surgery that day to get a new prescription. The team (it is unclear from the notes, who) tried to contact Mr S the next day to confirm he had collected his correct medication but he did not answer the phone. Consequently the team phoned Mr S' father who confirmed that his son had collected the new medication and was now taking it.

Mr S missed his next appointment with his EIS Care Coordinator on 15 October. He was seen on 22 October. He denied experiencing any psychotic symptoms though he admitted he still kept a knife in his bedroom for protection. He denied thoughts of self-harm or harm to others.

[2] A male, adult inpatient ward
[3] To our knowledge this was not reported as an incident

Mr S attended the Urgent Care Centre (UCC) at 2110hrs on 10 November 2015. He told staff he had been locked out of his flat and asked to be admitted. Mr S was seen by the Psychiatric Liaison Nurse (PLN) who assessed that Mr S did not require an admission. The PLN offered to help Mr S identify a 'safe space' for the night. Mr S refused this offer but agreed he would contact the EIS the next day. Mr S expressed his hatred of Ms A during the visit. Mr S became verbally abusive and aggressive towards staff and was escorted from the premises by hospital security staff. Mr S was considered by staff at the UCC to be a moderate risk to others due to his aggressive behaviour but that he did not need to be admitted.

Mr S attended the UCC a second time at 0340hrs on 11 November 2015. He told the PLNs that he had attended the homes of his father and sister before lastly attending his own flat, where he was unable to gain entry. He reported trying to (unsuccessfully) open the door with a knife and cutting his hand during the process. Mr S asked for a psychiatric assessment and to be admitted. The PLN's deemed that Mr S' mental state had not altered since his earlier assessment. He was told a bed was not available and there were no changes to his plan (i.e. for him to see EIS in the morning) at which point he became verbally abusive and left the UCC.

Ms A was found dead at her home on 11 November 2015. She was 50 years old at the time of her death. Mr S was 22 years old at the time of the incident.

Mr S pleaded guilty to manslaughter on the grounds of diminished responsibility on 19 December 2017. He was detained indefinitely under Section 37 and 41 of the Mental Health Act.

Findings

Mr S' risk assessment and risk management in Accident and Emergency (A&E) on 10th and 11th November 2015

The Department of Health[4] (2009[5]) describes risk assessment as:

"…working with the service user to help characterise and estimate each of these aspects. Information about the service user's history of violence, or self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that's available, and their more general social contacts could all be relevant. It is also relevant to assess how a service user is feeling, thinking and perceiving others not just how they are behaving."

It defines risk management as:

"… developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include a set of action plans, the allocation of each aspect of the plan to an identified profession and a date for review."

The Trust risk assessment and risk management policy for all mental health and allied specialties (MHAS) clinical staff (2014[6]) describes the principles of good risk clinical assessment to include:

- *"Good clinical risk assessment and management requires working with service users and carers in a collaborative manner*
- *Ensuring care and treatment plans are recovery-focused and person-centred*
- *Staff consider the extent to which they may need advice from carers, family members, colleagues, and other services or agencies, especially when someone's circumstances or behaviour change unexpectedly."*

Risk assessments should be updated when a significant risk event has occurred, as part of CPA review, upon transfer (or discharge) to/from a service, and at the discretion of staff.

The Policy details the clinical risk assessment process which includes reviewing a checklist of risk factors, recording risk events, history and/or the risk summary, and completing documents (e.g. risk management plans) and care planning. Management plans for immediate risk can be completed within the progress notes. Medium to long term risk management plans should be completed for service user's requiring ongoing care. Ongoing safety concerns should be updated within the progress notes and care plan actions if appropriate.

Mr S attended A&E twice on 10th and 11th November 2015. We set out below details of both attendances and the assessments undertaken by the Psychiatrist Liaison staff.

- **10th November 2015**

Mr S was referred by the Urgent Care Centre (UCC) to the Psychiatric Liaison Service at 2015hrs on 10 November 2015. He was seen by a Psychiatric Liaison Nurse 1 (PLN 1) at 2135hrs. Mr S said he had attended the UCC because his flat has been broken into and he was locked out having lost his keys. He had also lost his phone. Mr S told the UCC doctor

[4] https://www.gov.uk/government/publications/assessing-and-managing-risk-in-mental-health-services
[5] This is the most recent Department of Health publication available.
[6] The policy was due for review in December 2017, extended to September 2018

that he wished to be admitted to Frays ward. Mr S said he was not taking his prescribed medication though was unsure for how long.

Mr S initially presented as engaged and polite. His appearance was well kempt and there were no signs of self-neglect. Mr S said he wished to be admitted to Frays ward so they would help him sort his accommodation because he was not happy with the current arrangements.

Mr S became agitated, kicking furniture and throwing a bottle, and verbally aggressive towards PLN 1 when told a bed was not available on Frays ward and other options were presented to him. Security and another PLN, PLN2 attended. Mr S declined the PLNs' offer to help him identify a 'safe place' for the night though agreed he would contact the EIS in the morning with a view to discussing new accommodation and restarting his medication.

Mr S told staff he would not go to his father's but would sleep on the street. Mr S declined the PLNs offer to contact his father or flatmate, Ms A. Mr S continued to swear at the staff and terminated the interview by walking away. He was escorted from the building by Trust security staff.

Mr S' mood was recorded in the risk assessment as euthymic (stable/normal). He showed no signs of thought disorder or psychotic symptoms and denied any thoughts or intention to hurt himself. It was noted that Mr S did not want to go home as he did not believe his flatmate would let him in. *"No intent to harm others disclosed"* was recorded in the notes. Mr S was deemed to have some insight in to the fact he was not taking his medication and that he needed to see his EIS care coordinator.

Under the 'Capacity' section of the risk assessment it was recorded:

*"No reason to doubt his capacity. He was able to understand, retain, weigh up and communicate his decision to us. He terminated the assessment and did not want us to help him find somewhere for him to go tonight including dad or friend's. He also refused to go home as he stated that his flatmate, who he called "b***h who I hate", will not let me in."*

The impression of Mr S in the risk assessment was that he did not have acute mental health symptoms that warranted admission to hospital or undertaking a Mental Health Act Assessment.

Mr S' risk to self was recorded as 'low/moderate'. His risk to others was recorded as 'moderate'. It was recorded *"Got quite agitated and verbally abusive towards staff members. Had kicked furniture in the UCC cubicle and thrown his drink bottle across the room"*.

Mr S' risk assessment was partially completed; the 'medium/long term risk and crisis management plan' was not completed. The PLNs were unable to formalise a discharge plan with Mr S who terminated the assessment by walking away. He was escorted from the premises by Trust security staff.

The PLNs planned to fax the risk assessment to Mr S' GP and EIS, asking EIS to follow up with Mr S urgently in the morning. The fax was sent to the EIS and Mr S' GP at 0040hrs on 11 November 2015.

- **11th November 2015 (notes written at 0632hrs)**

Mr S attended the UCC at 0340. He had cut his hand and asked for a psychiatric assessment. Mr S was seen by PLN1 and RHMN 1. Mr S told PLN1 and RHMN1 that he was attended the homes of his father and sister after he left A&E. He said he then attended his flat and tried to gain entry by using a knife he had borrowed from a neighbour. He reported he had accidentally cut himself with the knife.

Mr S' mental state and presentation were noted to have not changed since the earlier assessment. Mr S was asked why he wanted to speak to the psychiatric liaison service, to which he replied he wished to be admitted to Frays Ward. Mr S was told that there were no beds available and that a plan had been previously agreed with him. Mr S swore at the staff and left. Mr S was discharged from the Liaison Service with a view to EIS following up with him urgently (as per the earlier plan).

The PLNs assessing Mr S completed the risk assessment checklist and reviewed Mr S' risk history with him in line with Trust policy. While initially cooperative with the risk assessment process, the records indicate Mr S became progressively frustrated and unwilling to comply. The PLNs recorded they were unable to complete a risk management plan for him prior to his terminating the assessment. As a result, sending Mr S' GP and the EIS service his risk assessment, and asking them to follow-up urgently with him was an appropriate response.

Bed Management processes at the Trust

When Mr S attended the UCC on 10 November 2015 asking to be admitted, he was told a bed was unavailable. However it is unclear if beds were available or not, because Mr S' clinical presentation did not warrant an admission, and therefore staff did not seek a bed for him. The Borough Director told us, that had Mr S warranted an admission, he would have been given a bed, regardless of the capacity of Frays ward.

There is a patient flow protocol (2015) for Hillingdon Adult Services. The Patient Flow Manager is responsible for ensuring systems are in place to manage and monitor bed usage, working Monday to Friday, 7am to 3pm, though the service operates 24 hours. The protocol states *"The underlying principle of these protocols is that all Hillingdon patients requiring admission to hospital will be found a bed in a timely fashion"*. Referrals for a bed can be received from a variety of sources which include the psychiatric liaison team, A&E, the HTT, EIS and Police. Referrals should be submitted to the Riverside Centre for Mental Health Patient Flow Co-ordinator, who in turn should notify the HTT. The protocol sets out the differences in process according to the source of the referral (e.g. Hillingdon Hospital wards, the police, Section 136).

The Trust has a bed management protocol (2016[7]) for all acute inpatient staff. It sets out the roles of key personnel and the process for locating a bed in and out of hours. There is a separate escalation procedure (see below) that can be referred to in the event of a bed not being available within four hours.

The Trust has a Bed Escalation protocol outlining the steps staff should take if a patient is waiting for a bed, either in or out of working hours. After four hours a Datix report must be completed.

The Trust has an escalation process for adult mental health admissions via the emergency department. This details the process four and eight hours after the decision to admit. Contact details are provided for in and out of hours and for the neighbouring Trust, West London Mental Health NHS Trust (WLMHT). Information is also provided on how to manage a patient who is medically fit to be discharged from an acute setting, but requires ongoing mental health support.

A bed management meeting takes place on a daily basis at the Hillingdon site. The Borough Director chairs the meeting, which is attended by the borough clinical director, and representatives from the community and inpatient teams (e.g. acute, OPMH, A&E, Occupational therapy, consultants and ward managers). Similar meetings are held across other boroughs.

The meeting is a daily discussion about in and out of area placements, beds and assessments. The bed manager provides a daily report on the status of beds which is sent out 30-45 minutes before the meeting. We were given a copy of the bed management report template which details:

- Admissions and transfers
- Discharges and transfers
- Beds available
- Section 136/135
- CAMHS
- Breaches
- Outliers
- Inliers
- Foreign nationals

[7] This was scheduled for review in November 2018

- Extra Contractual Referrals (ECR)
- B&B
- Bed requests
- Pending cases

We were given a copy of a completed bed management daily update, for 9 November to 12 November 2018. The bed manager report is emailed daily to a number of staff across the community service, including the bed manager, team leaders, service managers and the Borough Director. The Head of Patient Flow sends a 'weekend bed availability' report to service managers each Friday (we were provided with an example of this email dated 15 February 2019). This report details a breakdown of the available acute beds, including escalation and PICU, across the Trust six sites (including Milton Keynes). The email also sets out senior manager cover for the weekend (i.e. who should be contacted if a matter needs to be escalated).

The bed management meetings are not minuted, but action points are logged, and the aforementioned bed management update is issued daily (reflecting the previous meeting's discussion). The new style of bed management meeting has been in place for approximately two years.

Members of the community team also attend an inpatient bed management and white board meeting.

The Borough Director told us that in reference to Mr S, had he required admission, a bed would have been sourced. If there aren't any beds (including leave beds and AWOL beds after 24 hours) available on site, beds can be sourced on a Trust-wide basis (e.g. London and then Milton Keynes). Beyond the Trust, contractual arrangements are in place with neighbouring providers, WLMHT and Newham University Hospital, where the Trust can 'buy' a bed. In the event of a bed still being unavailable, the Trust will source and fund a bed in the private sector.

The Trust provided an example of its weekly Bed Usage report (dated 5-11 February 2019) detailing daily Trust-wide bed use by Borough, ECR and breaches[8]. The Trust provided details of how it monitors out of area placements (i.e. ECR). Local management of ECRs sits at borough level – in Hillingdon this will be recorded on the Bed Management log. Where appropriate, local community staff will be asked to review the ECR placement. ECRs are discussed daily and Bed Managers are responsible for maintaining contact with external providers. We were given the ECR update report for January and February 2019, detailing 20 ECRs. The ECR update report provides a breakdown of ECRs by local service, provider, status on admission, date of admission, date of discharge (if appropriate), daily bed rate and the total number of out of area bed days for each patient.

The Trust provided an example of the Bed Management Action log (recording actions between 19 December 2018 and 6 February 2019). Examples of actions recorded include:

- *"Clinical Guidelines for managing Drug and Alcohol issues in inpatient Units raised at the Bed Occupancy Board*
- *Follow up investigation regarding CAMHS admission to adult bed"*

The actions all had deadlines though some were recorded as 'planned' under status.

Hillingdon mental health services has a number of bed management protocols and processes in place to manage and monitor demand, admissions and out of area placements.

[8] Breaches are categorised by 4-8 hours, 8-12 hours, 12-24 hours and 24+ hours.

Housing management/allocation process and communication with Mental Health services and clarification of responsibilities

There is a shared protocol between the London Borough of Hillingdon and the Trust called 'London Borough of Hillingdon and CNWL Riverside Mental Health Joint Discharge Protocol'. First drafted in February 2018, we were told that the Trust works to the protocol, though it is not clear if it has been formally agreed by the two organisations. The purpose of the protocol is to *"improve joint working between housing and mental health services around the discharge process from inpatient wards, with a particular focus on preventing homelessness and minimising delayed discharge"*

The protocol is written for patients who are fit for discharge but may not be able to return to their previous accommodation or previously had no fixed abode.

The Trust has a partial Section 75 Agreement with the London Borough of Hillingdon (the Local Authority). Section 75 agreements are arrangements between a local authority and NHS Trust to pool resources and delegate responsibilities[9]. The contract details integrated team management and funding arrangements between the Trust and Local Authority from 1 April 2018 until 31 March 2023. The Trust has Local Authority employed social workers as well as Trust employed social workers.

The agreement sets out that the Trust will have a role in supporting patients to access:

"…appropriate housing or supported accommodation and appropriate levels of financial benefits"

However, it is the Local Authority that is ultimately responsible for providing patient housing within the borough. The Local Authority commissions and manages housing contracts. Ability Housing, a private contractor commissioned by the Local Authority, provide accommodation, floating support and a range of services to residents (e.g. boiler maintenance). Similarly, Comfort Care, a provider which offers accommodation and supported accommodation, is commissioned by the Local Authority. At the time of the incident, Hestia Housing held this contract but it was terminated in 2016.

The Borough Director told us that housing remains a problem within the borough in terms of process and availability, but the service had improved (e.g. via the joint working protocol) and that there had been good integrated working.

We were told that if a similar scenario to that of Mr S arose, in which there was an inappropriate[10] placement, it would be the responsibility of the Comfort Care employee to contact the duty mental health team and/or the patient's care coordinator. The care coordinator would also have a responsibility to raise concerns with the housing provider.

Care coordinators are required to undertake a placement review with patients within six weeks of their placement, completing a 'placement review form' as part of this process. Further reviews are required at six months, and then on an annual basis. This process has been in place since 2013 (the terms of reference do not extend to considering this in the context of Mr S).

We were told by the Borough Director and Community Mental Health Service Manager that pathways between Housing providers and the Trust had been strengthened, and, there was an expectation the partial Section 75 agreement would further cement housing processes between the Trust and Local Authority. The Borough Director and Community Mental Health Service Manager talked us through an example in which there had been concerns about the

[9] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library/integrated-commissioning-and-provision

[10] Mr S was in his early twenties and Ms A was 50 years-old at the time of her death – we do not consider this an appropriate living arrangement.

placement of a vulnerable patient, which in turn has led to the Trust liaising with the Local Authority, Trust legal services and MARAC[11]. The Borough Director told us she was confident the appropriate pathways were in place for the Trust to raise concerns and/or respond to inappropriate placements.

The Trust has a joint working protocol and partial section 75 agreement in place with the Local Authority to manage housing. It is the Local Authority that is the responsible for housing patients, maintaining properties and responding to any concerns, including inappropriate placements. There are processes in place by which the Trust can raise concerns and/or liaise with the Local Authority about Housing placements.

[11] Multi Agency Risk Assessment Conference

Trust internal investigation action plan

The Trust internal investigation into the care and treatment of Mr S was completed in August 2017 and signed off in November 2017. The investigation made nine recommendations, plus two fixed[12] Trust recommendations, 11 in total.

1. General Observations

- The action plan was signed off as complete by the Divisional Medical Director on 12 July 2018 with the following comment: *"Assurance is given that all the actions within this document have been implemented and have been effective. These have been fully understood by front line staff as appropriate and others as needed."* The local Care Quality meeting is responsible for monitoring the action plan.
- The action plan was signed off as agreed by Borough Director/Clinical Director as follows:
    - Borough Director, Hillingdon Community Service, 30 October 2017
    - Clinical Director, Hillingdon Community Service 30 October 2017
    - Director, Community Services, 14 November 2017

  The individuals are listed by name only – we have included their roles for the purpose of this report. In addition some actions are assigned to the responsibility of managers below Director level. It is not possible to confirm in some cases whether individual actions on the action plan have been signed off by those allocated responsibility.
- In some areas greater precision and consistency is required in the wording of action plan recommendations and actions to provide greater clarity and assurance that specific recommendations, in the context of this particular serious incident, are being captured in the actions implemented.
- There are examples of delays in taking actions to implement recommendations, the reasons for which are not clear from the action plan evidence. The Trust has missed action deadlines in several instances and in some cases action completion dates have been incorrectly recorded.
- We have highlighted for the Trust in the table below additional evidence which would be helpful to provide further assurance that the actions resulting from the investigation's recommendations have been implemented or there are clear plans to do so.

  Recommendation 1: The positions of individuals signing off key assurance documents should be stated.

[12] Specific to sharing the report with the patient, family and those/the services involved in the provision of care and treatment

2. Summary of Action Plan Progress

Recommendation and Actions *(in italics)*	**Key Observations (see Section 3. for detailed assessment)**	**Outstanding Evidence**	**Status (RAG rated*)**
Investigation findings to be shared with the patient/family (fixed) • *To feedback outcome of Panel of Inquiry to victim's family, the patient and patient's mother in accordance with the duty of candour and written consent given by patient.* **Responsibility: Lead Investigator** **Target Date for Completion: 31/12/17**	• Evidence that a meeting took place on 1/2/18 to share the investigation findings with Mr S is provided in the Trust's Action Plan update. Mr S' mother and father were invited to the meeting but did not attend. • Email correspondence indicates that Mr S gave written consent for the report to be shared with his parents but the associated direct correspondence from Mr S has not been provided. • Email correspondence indicates an intention of sending the report to Mr S' parents, respond to any queries and invite them to a further meeting. However, there is no evidence provided by the Trust as to whether and when this happened and whether there was further follow-up. • The wording of the action is not explicit in terms of sharing inquiry findings with the victim's family. • The Trust Head of investigation (and SI author) wrote to the victim's son on 16 February 2016 to offer condolence and advise the Trust would be undertaking an investigation, the final report of which, they would share with the family. • The Trust Head of investigation (and SI author) met with the victim's son and brother on 29 April 2016 to discuss the case and gather information about the victim. The Trust sent follow-up letters and an email to the son, in May and July 2016, respectively. • The Trust Head of investigation (and SI author) wrote to the victim's son on 26 January 2018 (report completed in August 2017 and following executive assurance, submitted to commissioners in November 2017) to advise of an addendum to the report that was submitted during the factual accuracy process. The report was shared with the victim's family.	• None	**GREEN**

	• The meeting with Mr S took place on 1/2/18 and the action is recorded by the Trust as complete as at this date. The Trust did not meet the target date for completion of 31/12/17.		
Investigation findings and action plan to be shared with all those involved in the care and treatment of the service user, and with other teams/services as applicable, for the purpose of learning. • *Report to be reviewed at QGG, team meetings and the quarterly feedback from SIs meeting.* **Responsibility: Borough Clinical Director** **Target Date for Completion: 31/12/17**	• The Colham Green business meeting agenda dated 6/12/17 detail the SI[13] under 'safety'. • There is evidence of discussion of the investigation findings at the Quality Governance Group (QGG) meeting of 11/12/17 for Hillingdon Borough. The meeting was attended by staff from a number of services including the HTT, EIS, CMHT East and West and inpatient ward manager. • We were told all managers are expected to attend the QGG and cascade to their business meetings. Attendance for the meeting on 11/12/17 was at 80%. • The responsibilities for and timing of the actions noted in the meeting minutes are unclear with respect to examining the recommendations and sharing with teams. • The Clinical Director advised in March 2019 that the SI had not been discussed at the quarterly SI meeting, but would be raised at the next meeting. • Attendees of our January 2019 focus group (representing the CMHTs and EIS) confirmed that they were familiar with the case and that the report had been shared with them • Responsibility for the action was assigned to the Borough Clinical Director, who has signed off the action plan. • The action is marked as complete as at 11/12/18, the date of the QGG meeting, however the report was not reviewed at a quarterly SI meeting.	• Minutes of next quarterly feedback SI meeting	**AMBER/ GREEN**
1. Borough and Clinical Directors to be assured that care coordinators and the operational and clinical	• The Trust has attached two relevant policies to the action plan update:	• Evidence of the communication to staff to	**AMBER/ GREEN**

[13] The meeting minutes are anonymised but the Trust confirmed that Mr S' case was on the agenda.

managers in EIS and inpatient teams adhere to the CPA and all policies relation to Admission/Transfers and Discharge to maintain robust communication and continuity of care • *Relevant policies to be recirculated to all Hillingdon Clinical Staff to ensure borough wide awareness.* • *Ensure that all staff are aware of the revised model of care implemented in 2016, which addressed the issues raised prior to the completion if this report.* **Responsibility: Borough Director** **Target Date for Completion: September 2017**	• CNWL's standard operating policy for Adult Community Mental Health Teams – Hillingdon Mental Health, dated April 2016. It was reviewed in 2018. • Harrow and Hillingdon Early Intervention Service (HHEIS), Operational Policy, dated March 2017. It was reviewed in 2018. • Both policies state the audiences for essential reading and awareness purposes which taken together covers all relevant staff. • The EIS operational policy was included in the EIS Quality Governance report submitted to the Care Quality meeting in September 2017. • However there was no evidence to confirm that these policies are all the relevant policies concerned, and have all been recirculated to Hillingdon clinical staff. • There is no specific evidence to provide assurance that all staff are aware of the revised model of care implemented in 2016 based on the above two policies. • Responsibility for the action was assigned to the Borough Director who has signed off the action plan. • The action is marked as complete as at 11/12/18. The Trust missed the target date for completion of September 2017. However, as indicated above, there may be some outstanding actions to be taken. • We met the Borough and Clinical Directors and the Community Mental Health Service Manager in November 2018. They told us that care plans and risk assessments are audited on regular basis and spot checks are regularly undertaken. They told us staff have been given more training e.g. in risk assessment (we discuss this under embedding learning) and root cause analysis. • The Trust changed its record management system in early 2019 from JADE to SystmOne and there is an expectation that this will facilitate risk assessment (i.e. the system is more user friendly for staff).	reissue the policies in the context of this action. • Evidence of staff being made aware of the new model of care through communication, guidance or training.	

	• The Community Mental Health Service Manager told us that there is an expectation for team managers to ensure risk assessments and care plans are completed and in date. There is a divisional Performance Manager who monitors performance and reports any breaches at the weekly Senior Team Meeting. • Attendees of the January 2019 focus group confirmed that risk assessments and care plans were regularly audited and subject to spot checks. • The weekly Senior Team Meeting is attended by the Borough Director, Clinical Director, Deputy Borough Director, Community Mental Health Service Manager and Inpatient Service Manager. The performance and governance leads for Hillingdon are also invited to attend part of the meeting (as required).		
2. Clinical and Borough Directors to be assured that Hillingdon MH Service staff are meeting the requirements of CNWL Risk Assessment and Management Policy with particular attention to ensuring that all known risk factors are updated in the care plans and appropriate risk management plans are devised. • *Regular audit of compliance with risk assessment completions will continue and results actioned accordingly* **Responsibility: Clinical Director/Borough Director** **Target Date for Completion: 31/12/17**	• The Trust provided EIS Quality Governance reports for 2016, detailing audits • The Trust provided a copy of EIS Quality Governance report submitted to the submitted to the Care Quality meeting in September 2017. A number of audits are detailed in the report including an EIS risk assessment audit for June 2017. • The Trust provided the Goodall Division Quarterly Governance Report received by the Goodall Division Board in July 2017. The report sets out a number of quality indicators including community risk assessments. Hillingdon achieved 90% compliance against a target of 95%. This was above the Trust average of 85%. Records that didn't comply with Trust policy had either not been updated, or the care plan did not reflect the risk assessment. • The Goodall Division Quarterly Governance Report received by the Goodall Division Board in July 2018 detailed 88% compliance by Hillingdon, against a target of 95%. The report provides dialogue to explain the scores (e.g. care plans needed to be updated)		**GREEN**

	• The Trust has provided Quality Account audit reports for Quarters 1, 3 and 4[14] in 2017/18 (audit reports were also provided for 2016/17). The reports details performance on audit compliance against a target of 95% for all categories of patient and by team. Hillingdon compliance rates for Q1 and 3 are consistent with the Trust's statement of "good compliance". The compliance rate for Q4 community risk assessments was 88% • The Trust provided an EIS audit report covering December 2017 – March 2018. The report is based on 199 responses and details patient factors that include alcohol use, use of anti-psychotic drugs, family intervention, CBT and Supported Employment Programme. • The Trust provided a document called 'Improving Risk Assessment and Safety Planning in Jameson Community Teams'. The document details a quality improvement project to improve risk assessment and risk management across Brent community mental health and early intervention teams. The document is undated but contains a project plan spanning March 2018 to December 2018. Some tasks are listed as 'not started'. • The Trust provided a document called 'Risk Assessment and Safety Planning – what does good look like?' The document details areas of good practice but is undated and does not say who the target audience is, or if it has been shared. • The divisional Performance lead undertakes benchmarking, comparing the services performance to that of other divisions across the Trust. • The Borough Director told us risk assessments are routinely monitored through audit and regular spot checks. • The Clinical Director chairs the monthly Quality Governance Group (QGG). It is an open meeting which all staff and service users (in		

[14] We were provided a document named 'Q2 2017-18' but the report was for quarter 1.

	part) can attend. Audit results and quality improvement projects are discussed at this meeting. • Focus group attendees told us they were confident risk assessments were completed in a timely manner, due to regular audit assurance, and that care plans must[15] be updated within seven days of a new risk assessment to reflect any changes. • However there were concerns that the recent change in records management from Jade to SystmOne might initially create some challenges in terms of all patient information being transferred, but this had not been tested. • Tableau provides team managers with an overview of care coordinators workloads and whether risk assessments and care plans are up to date. • On the 12 November 2018 we undertook a case note review of six cases. These were randomly selected by us from the Trusts community caseloads. Three were from EIS and three from local CMHT's. All six had evidence of CPA reviews within Trust policy and five of the six had completed and updated risk assessments in line with Trust policy. When reviewed, the one risk assessment that had not been updated had been reviewed in the relevant CPA meeting, but not updated in the records. The actual assessment itself had not changed in any noticeable way and the existing risk assessment was valid for the client's presentation at that time. • Responsibility for the action was assigned to the Clinical Director and Borough Director, both of whom have signed off the action plan. • The action is marked as complete as at January 18. The Trust marginally missed the target date for completion.		

[15] It is a Trust CQUIN (Commission for Quality and Innovation national goals) that care plans are updated within seven days of a new risk assessment.

3. Clinical and Borough Directors to be assured that Hillingdon MH Service staff are skilled and competent in assessing and managing dynamic and emerging risk behaviours for patients on CPA. • *A training workshop will be held with regard to risk assessment to ensure that staff training is refreshed in this area which will include all clinical disciplines of staff.* **Responsibility: Clinical Director/Borough Director** **Target Date for Completion: December 2017**	• Risk assessment and Suicide prevention awareness training was offered to all Hillingdon CMHT staff in May 2018. Three sessions were held at different sites. 46 staff attended the risk assessment session in total covering a range of teams and roles including: CMHNs, RMNs, OTs, team leaders, PLN, HCAs, student nurse, CPNs, peer support worker, social workers, and activities' co-ordinators. • The course was a one-day session covering risk assessment in the morning and suicide prevention awareness in the afternoon. The Trust provided detail of the course content for both sessions. • We are unclear if all required staff were invited and attended the risk assessment training. The training is not mandatory but all staff are expected to attend. • The action is marked as complete as at 31/5/18, following the final training session. The Trust has missed the target date for completion of this action of December 2017. • A Trust-wide clinical Risk CMHT assessment workshop took place on 12 July 2018. All teams with Adult CMHT and EIS services were invited with a view to 3-4 individuals from each team attending. The invitation was sent to the Service Manager and copied to the Clinical Director. We do not have the attendance detail • Two training sessions in 'Clinical risk and safety management' for community staff took place on 8 November 2018. The Trust reported full attendance to both workshops. • Responsibility for the action was assigned to the Clinical Director and Borough Director; both have signed off the action plan.	• Confirmation that all staff required to attend were invited and received the training	**GREEN**
4. The panel recommends a review of the resources and practices at Colham Green Rehab to consider to the following:	• The Care Quality meeting minutes dated 10/10/17 detail that the Colham Green Operational Manager reported staffing levels had been reviewed at the unit.	• Evidence of oversight by Clinical and Borough Directors	**GREEN**

• The assessment of the effectiveness of the recent input from psychology services • The practice of a full and comprehensive psychological multidisciplinary assessment of all patients • Phased discharge to supported accommodation to ensure effective transition to independent living • Support and supervision of junior doctors completing discharge summaries to ensure they are of a high standard • *Review of the resources and practices at CGR in these 4 areas to be carried out* **Responsibility: Colham Green Operational Manager** **Target Date for Completion: 31 October 2017**	• Email evidence (sent by the Colham Green Operational Manager to the Quality Governance Facilitator for Goodall division on 9/12/17) indicates that cover was reviewed although the exact timing and extent of the review is unclear from the correspondence. • It confirms that psychologist cover was in place at Colham Green Rehabilitation unit from 2016 and consultant and SpR cover since 2017. Psychology cover is provided two days a week. When we met with the team it explained recruitment had been a challenge and that they'd advertised several times for a part-time psychologist in 2015. • The team at Colham Green explained that multi-disciplinary team meetings (led by the consultant psychiatrist and attended by the team junior doctor, the occupational therapist and nursing staff) were the forum where it was decided if a patient required psychological support. • The consultant psychologist (who divides his time across sites) confirmed he would then be informed of this request. He will also undertake screening sessions upon patient admission, if requested. He attends ward rounds and routinely visits the unit. He told us that any member of staff can submit a psychological referral to him and he will undertake an assessment, providing a same-day decision. He will give advice to discharge services, though his remit ends when the patient leaves the service. He advised all patients are told they are welcome to visit the unit, see staff etc, if they think this will be helpful. We were told this helps to avoid patient drop off. The Consultant Psychologist for Colham Green told us he also undertakes work with patient families where appropriate. • The Operational Manager's email correspondence to the Quality Governance Facilitator for Goodall (dated 21/2/18) advises that phased discharge is considered on a case by case basis and that the Colham Green team are aware of this and consider as part of discharge planning for all patients. An example case note included in the action plan evidence shows how phased leave has been considered for one patient.		

	• We were told that the discharge pathway for the unit is 6-18 months, and that placement at the unit is a transition period (typically from inpatient services to the community). Occupational therapy has a significant role in working with patients to identify their next steps (during their time at Colham Green and after their discharge). • Discharges are phased and considered on the basis of risk, and there is a mechanism to recall patients. Once in the community, the patient is the responsibility of the community team. Colham Green has undertaken outreach work with patients in the past and will offer telephone support, though the patients are no longer part of Colham Green's caseload. • An employment specialist visits Cohlhm Green every two weeks and works with patients seeking voluntary or paid employment. The Consultant psychiatrist assesses which patients are appropriate for employment. We were told that at Colham Green emphasis moves from the unit to patient futures' in the community. We were given examples of patients currently in voluntary placements and paid jobs, including one patient who went on to complete nursing training. The Colham Green occupational therapist has links to the local football team which is run by service users in the community. • When we met the team at Colham Green they talked through the phased discharge process and were able to provide a recent example of an extended phased discharge to support a patient who needed a lot of support to facilitate his/her move from the unit • The Trust reported in its completed action plan that the increase in staffing had meant there was additional support and supervision available for junior doctors, including in relation to completing discharge summaries • Evidence indicates that actions had been taken before the target date for completion to review resources and practices at CGR and the Operational Manager has had oversight of the implementation of the changes.		

	• We randomly selected and reviewed three case notes for patients at Colham Green who had been discharged, and found discharge summaries were completed in line with expected practice. The Consultant psychiatrist for Colham Green advised that she reviewed each discharge summary as part of the discharge process. • In terms of supervision for junior doctors, we were told the junior doctor's timetable ran in parallel with the consultant psychiatrist. The junior doctor is based in the community for half his/her time and this is where the majority of supervision is undertaken. The consultant psychiatrist has a weekly meeting with the junior doctor to discuss any concerns/issues. • There is no evidence provided of oversight of these changes at Director level. • *We note that Mr S was discharged from Colham Green in March 2015 and the concerns identified in the Trust investigation pertaining to the unit, did not bear any relation (specific or casual) to the incident in November 2015. On this basis we conclude that the concerns identified at Colham Green would have been better addressed in a separate review process.*		
5. All Hillingdon MH services to ensure that all policies are developed and managed in keeping with the policy on the Development of Trust-wide Procedural documents August 2016, with particular attention to ensuring that they are finalised documents. • *The Care Quality meeting will ensure and sign off any new procedures to ensure that this is met.*	• The meeting agenda for the Quality Governance Group and Care Quality Group for 8 January 2018 shows a standing agenda item for "Guidelines/Policy/SOPs/ New procedures for review and/or approval", thereby confirming that this group is responsible for signing off new procedures. • No minutes of subsequent meetings were provided to assess compliance further. • The recommendation refers to a policy on the Development of Trust-wide Procedural Documents, dated August 2016, which we have not seen. There are some governance aspects around the following policies which require attention in terms of good governance practice and finalisation:	• Policy document "Development of Trust-wide Procedural Documents" • Evidence of operation of tracking system for changes to policies and procedures • Minutes of Care Quality Group meetings to assess ongoing compliance with sign-off requirements at this group	**RED/AMBER**

• *A tracking system will ensure any proposed procedural changes are made at this level with regard to change in clinical practice, as well as ensuring Trustwide and national guidelines are met.* **Responsibility: Clinical Director/Borough Director** **Target Date for Completion: October 2017**	• The CNWL standard operating policy for Adult Community Mental Health Teams (Hillingdon) dated 18 April 2016, does not appear to have been formally signed off and its status is unclear in terms of update (due February 2018). • The HHEIS operational policy was signed off 21/3/17 and was due for review 14/6/17. There is no evidence that this policy has been reviewed by the due date stated. The policy is not signed and does not indicate the responsible individual. • Evidence has not been provided with regards to the tracking system to ensure adherence to this process. • The action is marked as complete as at 11 January 2018 and therefore missed the target date for completion. As indicated, further evidence is required to demonstrate that this action has been fully addressed. • Responsibility for the action was assigned to the Clinical Director/Borough Director; both have signed off the action plan.	• Confirmation that Borough and Clinical Directors have oversight through the CQG	
6. Borough and Clinical Directors to be assured that there are clear and explicit processes in place in EIS to facilitate caseload management between frontline practitioners. • *To ensure that clear transition processes are embedded within the model of care* **Responsibility: Deputy Borough Director** **Target Date for Completion: November 2017**	• The Trust makes reference to the policies provided under Action 1 above as evidence for implementation of this action. • The recommendation and associated actions refer to distinct aspects of operational management and care. Caseload management is not the same as transition processes. This requires further clarification in order to assess the status of this part of the action plan. • The policies provided by the Trust make reference to processes for caseload management, transitions between teams and services and care-co-ordination. However, this is generally in high level terms rather than “clear and explicit” processes. • This action is marked as complete as at 19 December 2017. However, more evidence and clarity is required to allow an assessment of the adequacy of the processes in place.	• Clarity on actions relating to the recommendation	**AMBER/ GREEN**

	• We discussed caseload management with the Community Mental Health Service Manager, Clinical Director and Borough Director. They told us there had been a number of changes to caseload management since the incident in 2015, and they were assured that processes were in place to monitor caseload management. Caseloads are capped at 20 with a ceiling of 30. Team managers and team leaders are also asked to manage a small case load of five to ten cases. • Daily EIS Zoning meetings provide a forum where staff can raise concerns about case load. • Supervision structures and record keeping have been strengthened. Caseload management is discussed as part of the supervision process. • The Community Mental Health Service Manager chairs the monthly Care Pathways meeting. The terms of reference for this group include acting as an enabler of ensuring effective service delivery, and safe and high quality care. • The Trust provided a breakdown of cases by care coordinator (180 cases) and a monthly breakdown of 201 referrals received between October 2017 and October 2018. • The Trust provided evidence of monthly monitoring of referrals (including commentary as to whether the referral criteria has been met) and upcoming discharges. • The Community Mental Health Service Manager told us some improvements were still required because they had patients – not EIS - waiting to be allocated a care coordinator. No cases were awaiting allocation in EIS. • We discussed caseloads with the focus group who confirmed that EIS try to limit this to 20. CMHT current caseloads for CPNs is 30, for social workers, 20. We were told caseload weighting was not always achieved, and that case complexity has increased, though ideally CMHT care coordinators were not allocated more than five		

	complex cases. Care coordinators can push back if they feel their caseload is too large/complex. • We were told it has been formally raised within the CMHT that the service is over capacity. As a result there is plan to do a full review of capacity with the CCG and GPs. We were told GPs were not always correctly referring to their team, though the discharge process to GPs was working well.		
7. The Zoning system should be reviewed by the EIS team for assurance that it is being followed, and that whenever changes to a lower zone are made, there is clear evidence recorded of the rationale for this. • *The model of care and the zoning system will assure that actions and decisions made in zoning meetings are now robustly recorded.* **Responsibility: Community Service Manager** **Target Date for Completion: October 2017**	• The Trust makes reference to the policies provided with the action plan as evidence for implementation of this action. These policies make reference to the zoning system but do not cover the recording of actions and decisions relating to zoning. • We also reviewed the Hillingdon Community Mental Health Teams, Duty Process dated 18 March 2017. This refers to the zoning system without explicit links to the recommendations and actions. • The Trust's Care Programme Approach Policy, dated 26 January 2015 does not reference zoning. • The Trust provided a Hillingdon and Harrow EIS protocol dated 6 April 2016, called '"*Zoning System" for targeting interventions'* which sets out the criteria for Red, Amber, Green and hospital zones. It describes the minimum standards for Red, Amber and Green Zones, and gives examples of why a client's zone might be regraded. • We were told by the Borough Director, Clinical Director and Community Service Mental Health Service Manager that the review of the model of care had led to a number of changes including to the zoning process. For example, Zoning meetings now occur on a daily basis. They each indicated that they were confident the Zoning process was working and would attend the meeting for further assurance. • We were shown examples of the daily recording of Zoning and weekly reports • The Focus Group confirmed that Zoning meetings occur daily	• Evidence of review of the zoning system by the Early Intervention Service • Evidence of assurance of adherence to the system and documentation of actions/decisions taken.	**AMBER/ GREEN**

	• However we do not have the evidence of any review of the Zoning system, or assurance given to the appropriate forum with regards to adherence to the system. • This action is marked as complete as at 19 December 2017. However, more evidence is required to allow a full assessment to sign-off fully on this action.		
8. Where team meetings are minuted, the Borough and Clinical directors to be assured there are effective governance systems in place, with particular attention to having clearly named individuals as the responsible person to progress the action, with clear expectations and contingency plans in place to support the outcome. • *The model of care and the zoning system will assure that actions and decisions made in zoning meetings are now robustly recorded.* **Responsibility: Community Service Manager** **Target Date for Completion: October 2017**	• The recommendation lacks precision as to the processes to which it refers. The action applies to the complete model of care and zoning system however the Trust's update only makes reference to new zoning meeting guidance. • The evidence provided is the Hillingdon Community Mental Health Teams, Duty Process dated 18 March 2017. This is not specific in terms of the assurance/governance processes and contingency planning referred to in the recommendation. However it sets out detailed procedures for recording an assessment and outcome on the JADE system, including risk assessment. • There is an EIS zoning protocol (dated April 2016) which sets out the criteria for different zones. The protocol directs staff to record any changes to Zoning on a Zoning spreadsheet. • The Focus Group told us that the daily zoning meetings fed effectively into risk assessment; 'red' patients are discussed daily, 'amber' weekly. • There is no clear evidence of new zoning meeting guidance. • The Borough Director and Clinical Director told us that they will attend Zoning meetings to gain further assurance that the process is working • This action is marked as complete as at July 2017. However additional clarity and evidence is required to provide assurance on completion of this action.	• Clarity on the focus of the recommendation • Evidence of revised procedures to reflect the governance arrangements required in the recommendation	**AMBER**
9. Borough and Clinical Directors to be assured that staff adheres to the Trust Care Records Standards April 2016 with particular attention to:	• The Clinical Director for Hillingdon recirculated the Care Records Policy dated 4 March 2016, by email on 7 December 2017. This was issued to a group of staff with a request to circulate to teams. It is not clear if this was further communicated to all staff as required.	• Confirmation that the Care Records Policy was recirculated with the accompanying email to all staff	**AMBER/ GREEN**

All clinical discussion about patients to be accurately recorded in the patients records. Where documented by admin staff they need to be accuracy checked by a clinician. • *Care Records Policy to be recirculated to all staff with a memo reminding staff about documentation.* • *Continue to participate in Trust care Records audit.* **Responsibility: Borough Clinical Director/Service Managers** **Target Date for Completion: 31 October 2017**	• This email reflected the wording of the recommendations. • The Care Records Policy makes reference to more detailed procedures to be followed in two further documents: CNWL Care Records Standards and Care Records Procedures. These documents have not been provided as evidence for the action plan review but are relevant; the Care Records Standards document is referenced in the recommendation. • The Care Records Audit Report for 2016/17 evidences participation in care records audit and was presented to the Divisional Board for assurance. The report was also presented to the CNWL Information Governance Group and CNWL Care Records Group. • Audits were undertaken between 2 November and 6 January 2017. Some teams did not submit returns (Hillingdon Mental Health – CMHT North, Oak Tree Ward, Community Rehab). • The report states that resulting team action plans are incorporated, into service line and Division action plans. A Quality Improvement Action Plan is attached to the report. • The Care records Audit report for 2017/18 evidences ongoing participation in care records audit. • Responsibility for these actions is assigned to Borough Clinical Director and Service Managers. It is good practice to assign responsibility to a single individual so that there is no blurring of responsibilities. • The actions are marked as complete as at 30 April 2017 however the email to staff regarding adherence to care records policy was dated 7 December 2017, indicating that the Trust has not achieved the target date for completion. • On the 12th of November 2018 we undertook a small case note review of six cases. These were randomly selected by us from the Trusts community caseloads. Three were from EIS and three from local CMHT's. All six had evidence that recent clinical contacts and discussion about patients were accurately recorded and all entries were made or verified by a clinician.	• Care Records Standards and Care Records Procedures documents dated April 2016	

***Key to RAG rating**

The RAG rating is intended to provide an indication only of the status of the action plan against the required actions based on the evidence provided by the Trust at the date of completion of this part of the review. These ratings may change should the Trust be able to share further evidence to substantiate actions noted as having been taken on the action plan update used for the purposes of this review. Additional evidence required is indicated in the table above.

RED	Significant elements of recommended actions not complete and significant gaps in evidence provided by Trust
RED/AMBER	Some actions not complete and significant gaps in evidence provided by the Trust
AMBER	Actions are complete but there are some significant gaps in evidence provided by the Trust
AMBER/GREEN	Actions are complete but there are some minor gaps in evidence provided by the Trust
GREEN	Actions are complete by due date and sufficient evidence has been provided by the Trust

The Trust provided extensive evidence of progress with its action plan, and we consider on balance, that the action plan has been successfully implemented. However there are a small number of gaps in documentary evidence that the Trust should seek to address with a view to achieving complete implementation of its action plan (e.g. zoning and a tracking system for procedural change)

Recommendation 2: The Trust should review the gaps in evidence we have identified with a view to providing NHSE with assurance within three months that it has comprehensively implemented its action plan.

Embedding lessons learnt and the impact on safety of Trust services

The service Clinical Director, Borough Director and Service Manager were all clear that there had been substantive changes at the Trust which has led to improvements in the service provision. In particular, they noted the introduction of the new EIS model of care, increased medical provision and improved zoning to have all led to improvements, though added some work was still required.

The Trust held risk assessment and suicide aware training sessions on 8 May, 22 May and 30 May 2018, attended by approximately 50 community staff in total. Teams represented included EIS, CMHT and the HTT. Inpatient and psychiatry liaison staff were invited to the suicide awareness training on 8 May 2018. Roles represented at the training sessions included CPNs, RMNs, student nurses, occupational therapists and social workers.

A Clinical Risk CMHT workshop took place in July 2018 and further clinical risk training was given in November 2018.

The Trust hold Learning from SIs meetings on a quarterly basis. The Clinical Director described this as a good forum attended by a number of staff, with a reasonable mix of staff, though in the past it had been primarily attended by doctors. The forum serves as a learning exercise, in which a recent SI will be presented and discussed. Attendees are given an opportunity to ask questions and challenge their colleagues, though emphasis is on learning as opposed to attributing blame. The Clinical Director told us in January 2019 that the most recent Learning from SIs forum had taken place in October 2018 and had good multi-professional representation.

Attendees to our Focus Group confirmed that they had attended SI meetings and described them as useful learning exercises. They added that relevant SIs will also be discussed at local business meetings and in the regular Psychology team meeting.

The Trust has taken steps to develop learning in relation to risk assessment and suicide prevention. Anecdotal evidence from staff indicates that the quarterly SI feedback meetings are useful and well received, though we cannot comment as to whether these – or the additional training – has impacted the safety of Trust services.

CCG monitoring of the action plan

The NHS Serious Incident (SI) framework (March 2015) says that CCGs are responsible for signing off and quality assuring Trust SI reports:

"On receipt of the final investigation report and action plan form the provider, the commissioner should acknowledge receipt by email. They will then undertake a quality assurance review of the report within 20 calendar days. Where necessary an alternative timescale may be agreed."

Commissioners must ensure:

"… the report, action plan and implementation of necessary actions meet the required standard. The serious incident report, closure process and meeting minutes must clearly describe the roles and responsibilities of those involved in the reporting, investigation, oversight and closure of the serious incident to demonstrate good governance and provide a clear audit trail. The commissioner must seek assurance that the report fulfils the required standard for a robust investigation and action plan."

The framework provides a closure checklist which can be completed by providers or commissioners as part of their SI sign off and closure process.

The Trust Director of Nursing and Quality signed off the internal report on 14 November 2017. The report was emailed to the CCG the same day.

NHS Harrow CCG – as part of North West London Collaboration of CCGs[16] - was responsible for signing off the Trust SI report and its action plan. The CCG Assistant Director of Quality and Safety signed off a SI framework closure checklist for the Trust report on 18 November 2017 concluding:

"Very detailed and well written report which explored all the contributing factors and identified root causes with very clear recommendations. Recommend closure"

The Assistant Director of Quality and Safety emailed the Trust Head of Serious Investigations (and co-author of the report) on 22 November 2017 to advise that the CCG considered the report and action plan to have been well written and appropriately detailed, and that the case would be closed. She added that she would follow-up in roughly six months with a view to establishing all the actions detailed in the action plan had been completed.

The Trust submitted its completed action plan to the CCG on 29 August 2018, nine months after the report was submitted.

The CCG was unable to provide any evidence that it had monitored the Trust's progress with its action plan, and it had not tested whether the actions had been completed. The CCG Assistant Director of Quality and Safety told us this was because historically the CCG had not had processes in place to systematically monitor SI action plans.

We were told that the CCG is currently reviewing its processes with a view to strengthening its assurance processes. The CCG gave us its first draft of a standard operating procedure (SOP) for 'the internal management of Serious Incidents utilising "Datix"', dated 24 August 2018. The draft SOP process section says the SOP is not a 'how to use' Datix guide and directs the reader to four appendices:

- *"Appendix 1 – Details, in a flow chart the overarching process for the management of serious incidents within the CCG*

[16] Hillingdon, Harrow and Brent CCGs

- *Appendix 2 – Details, in a flow chart, a more detailed flow of the responsibilities of the Patient Safety Team (PST)*
- *Appendix 3 – Where to find Datix "help" function*
- *Appendix 4 – SI approval process"*

We were told that the CCG looks to monitor the themes coming out of SIs and will undertake 'deep dives' to look at specific themes. There are also Clinical Quality Group (CQG) meetings with local providers every other month. Since October 2018, the CCG holds formal seminars with the Trust in the month between each CQG meeting. We were told that the CCG asks the Trust to go through themes identified through SI deep dives. Examples of themes reviewed include physical healthcare monitoring for mental health patients, risk assessment documentation, and ward activities used to reduce restrictive practice on wards.

We were told that the CCG undertakes quality assurance visits to look at organisational learning as part of its assurance processes. The quality assurance visits reports are presented at the CQG with recommendations for the Trust.

The CCG did not monitor the Trust action plan in line with NHS guidance. There is no evidence it monitored the Trust's progress with its action plan or undertook any assurance exercise to test the Trust's sign off of individual actions. The Assistant Director of Quality and Safety advised in an email to the Trust on 22 November 2017 that she would follow-up within six months in relation to the action plan but there is no evidence of communication or assessment beyond this.

The CCG is taking steps to strengthen its assurance processes but we note NHS guidance was clear in 2015 as to the remit of the commissioner in seeking that an SI report and action plan were robust. We are concerned that the CCG did not undertake any form of monitoring of the Trust action plan particularly given the serious nature of the case.

We do not know what assurance the CCG has that a similar scenario would not arise. The CCG has advised it must adopt a strategic approach to monitoring SIs and action plans (e.g. undertaking thematic reviews), given the number that it is responsible for, but it is unclear how this approach will give assurance that individual action plans are robust, monitored and complete.

Recommendation 3: The CCG should assure itself within the next three months that it has robust systems and processes in place to monitor and test individual SI action plans. This should include finalising its SOP for the 'internal management of Serious Incidents utilising "Datix"'

Recommendation 4: The CCG should undertake an audit of Serious Incidents within the past 12 months with a view to confirming that action plans were monitored and tested.

Appendix A

Interviewees

- Hillingdon Clinical Director
- Hillingdon Borough Director
- Hillingdon Community Mental Health Service Manager
- Colham Green Rehabilitation unit Manager
- Colham Green Rehabilitation unit Operational Manager
- Colham Green Rehabilitation unit Consultant Psychologist
- Colham Green Rehabilitation unit Consultant Psychiatrist
- Assistant Director of Quality and Safety, NHS Harrow CCG, North West London Collaboration of Clinical Commissioning Groups

Appendix B

Documents

- Mr S' clinical notes and risk assessments pertaining to 10 and November 2015
- Trust policies and procedures
- Service model
- EIS annual plan
- Bed management information
    - Bed management protocol
    - Escalation protocol
    - Bed usage report
    - Bed manager report
    - Bed management action report
    - Weekend bed availability report & email
    - On call staff guidance
- Meeting agendas and minutes
- Trust investigation and updated action plan
- Service documents (e.g. Colham Green Road policy)
- EIS caseload information
- Zoning information
- Details of training attendance
- Training course content/detail
- Governance reports
- Workshop feedback
- Mental Health Section 75 Agreement
- Risk registers
- Audit results
- EIPN audit report
- CQC EIS self assessment July 2017
- KLOE update February 2018
- Safeguarding Adults Review for Hillingdon Safeguarding Adults Board (March 2018)
- Colham Green Accreditation for Inpatient Mental Health Services paperwork