Independent Quality Assurance Review of Mr L Independent Investigation Oxleas NHS Foundation Trust action plan implementation

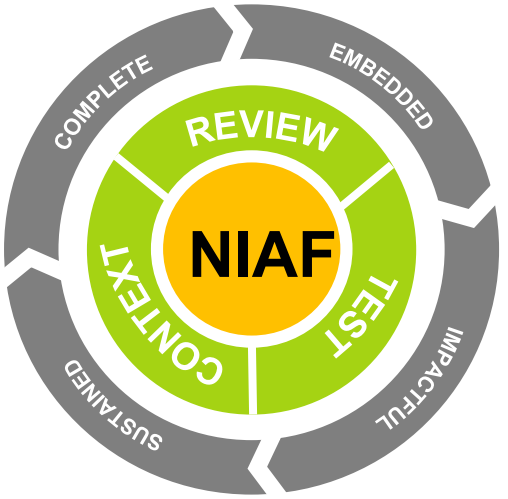
Ref: 2014/7319

Final Report

January 2021

insight integrity impact

Niche Investigation Assurance Framework



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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

Background and context for this review

On the morning of Sunday 2 March 2014, Mr L called the police to inform them that he had killed his neighbour (71 year old Mr Ronald Parsons). Mr L was arrested by police at his flat, and taken to Bromley Custody Suite where he made various admissions to the offence. On 3 March 2014 Mr L was charged with murder and remanded at Bromley Magistrates Court.

Mr L's contact with mental health services, including 11 previous admissions to mental health services, started in 2004. Prior to the homicide of Mr Parsons, Mr L had been admitted to Green Parks House under Section 2 MHA on 2 December 2013. This was converted to a Section 3 and Mr L was transferred to the Tarn, a PICU, on 6 December 2013. Mr L was discharged from the Tarn on Friday February 28th 2014 to his own flat with a two week supply of medication and an outpatient appointment to see the AOT Consultant Psychiatrist on 3 March 2014.

Oxleas NHS Foundation Trust ('the Trust' hereafter) undertook an internal investigation. After this, NHS England (London) commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Mr L).

Our investigation found that the recommendations made in the internal report did not adequately address the practice issues identified. We therefore made three recommendations intended to support the Trust in learning and improving services and practices.

The terms of reference for the independent investigation required Niche to undertake an assurance follow up review after report completion. This was in order to provide an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF), with issue of a brief written report on progress to NHS England (London). This is a high level assurance review only and does not include further site visits or interviews.

1. Executive Summary (cntd)

Review method and quality control

Our work has comprised a desktop review of documents including policies, procedures, action-plans, minutes and communications. It is important to note that we have not reviewed any health care records because there is no element of re-investigation contained within the review terms of reference. We used information provided by the Trust. This information has not been audited or otherwise verified for accuracy.

At Niche we have a rigorous approach to quality standards. We are an ISO 9001:2015 certified organisation and have developed our own internal single operating process for undertaking independent investigations. Our final reports are quality assured through a Professional Standards Review process (PSR) and approved by an additional senior team member to ensure that they have fully met the terms of reference for review.

The Niche Investigation Assurance Framework (NIAF)

Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a useful numerical grading system to support the representation of 'progress data'. We deliberately avoid using traditional RAG ratings, instead preferring to help our clients to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

Our measurement criteria includes:

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

2. Summary assessment on progress

Implementation of recommendations

Our assurance review has focussed on the subsequent actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

Our review has found that the Trust has completed and embedded in practice all actions arising from these recommendations and the Trust can demonstrate that these action are now sustained and routine practice cross the Trust

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In relation to progression of actions which have been agreed from the three recommendations made from our investigation report, we have rated the findings which are summarised below:

Summary

There has been significant and sustained improvement in changes to practice in relation to the recommendations and subsequent actions. We have not made any further recommendations.

Assurance review findings

3. Assurance review of the Trust's action plan

The terms of reference for this current assurance review require an assessment of the implementation of the recommendations which resulted from our independent investigation. We had investigated the care and treatment of a mental health service user (Mr L) by the Trust following the homicide of Mr Ronald Parsons in March 2014.

We found that it was not predictable that Mr L would kill Mr Parsons. However, whilst it may not have been predictable that Mr L would attack and kill Mr Parsons on that occasion, it was predictable that at some point in the future he would likely be involved with a violent assault given his forensic history. Alongside this, a number of other factors were not given sufficient attention prior to his discharge.

Although Mr L had improved shortly before his discharge such that continued admission on a PICU was no longer suitable, other professional views maintained that Mr L should have followed a care pathway through a longer term low secure placement to ensure that his illness and behaviour had stabilised. There should also have been a robust and proper care plan in place to support him, as required by Trust policy and best practice guidance. This care plan should have involved the housing association and local Environmental Health, and fully considered and mitigated any risks to his neighbours arising from their complaints about his anti-social behaviour and noise. These concerns were known by the care team. Because this proper discharge care planning did not happen we believe that the death or Mr Parsons was preventable.

However, we made three recommendations to promote wider systems learning intended to support the Trust in learning and improving services and practices:

Recommendation 1:

The Trust must ensure that where a violent patient has been admitted to its services following concerns by other agencies; or complaints by neighbours about anti-social behaviour and noise and that they have been made aware of:

- The risks are assessed appropriately.
- There are care plans developed to address anti-social behaviours towards members of the public (who may have been victims), and these may involve other agencies.
- There is a robust discharge planning process that fully involves these agencies prior to discharge.
- The Trust should also work in partnership with other key agencies involved (local authority, housing agency, police and CCG) to ensure that there are processes in place to support the routine sharing of information regarding any potential anti-social behaviour of suspected/known service users.

Recommendation 2:

The Trust should ensure that consideration about referral to MAPPA takes place for patients with violent histories and convictions for serious violent offences. Such referrals should consider safeguarding issues and risks of domestic violence for wider family members.
NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment.

3. Assurance review of the Trust's action plan

Recommendation 3:
The Trust must assure itself that all practices of seclusion and 'de facto' seclusion on the PICU, including where patients have been segregated from others after rapid tranquilisation, are fully compliant with the requirements of the Mental Health Act 1983 (amended 2007), the MHA Code of Practice and the MHA Reference Guide.
NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment.

Recommendation 1. The Trust must ensure that where a violent patient has been admitted to its services following concerns by other agencies; or complaints by neighbours about anti-social behaviour and noise and that they have been made aware of:

- **The risks are assessed appropriately.**
- **There are care plans developed to address anti-social behaviours towards members of the public (who may have been victims), and these may involve other agencies.**
- **There is a robust discharge planning process that fully involves these agencies prior to discharge.**
- **The Trust should also work in partnership with other key agencies involved (local authority, housing agency, police and CCG) to ensure that there are processes in place to support the routine sharing of information regarding any potential anti-social behaviour of suspected/known service users.**

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has provided policy for Clinical Risk Assessment Policy v1.4 Nov 2018. This provides guidance on the clinical risk assessment process including when and why to assess risk, and how this should be done using a combination of clinical structured judgement and actuarial information. We have also seen guidance on 'Raising awareness about anti-social behaviour' and the email trail to disseminate this, and discussion of the guidance in meeting minutes. This guidance includes information on definition, formulation and how to incorporate into care planning. • From the Progress report on actions from independent homicide investigations (February 2019) we have seen that a review of a sample of service users with documented concerns about risk was conducted in December 2018 by heads of nursing in each borough to establish there were records on the MDT templates and subsequent risk assessments, care plans and discharge plans and confirmation that consideration has been given to involvement of other agencies in these plans. This audit covered 14 services users across eight wards. All services users had evidence that their risks were discussed in the MDT, that the Risk Assessment included risk of anti-social behaviour, and the care plan showed intervention for any specific risk. In 12 of these cases there was evidence of multi-agency involvement. • The Trust has provided a 'screen shot' of the MDT Review/Ward Round template from RiO, which includes sections to identify family and service user views and other agency involvement.	The policy provides guidance on assessing risks, planning care, and discharge planning with consideration of anti-social behaviour. There is strong evidence of development, oversight and dissemination through Trust committee structures. Staff have been made aware of anti-social behaviour and its consequences for mental health service users through email and information provision. The Trust has provided robust evidence of how it trains staff in managing risk, including where there are aspects of anti-social behaviour through both STORM and DICES training. We have seen programme outlines and details of sessions as evidence. From the sample audit there is clear evidence that those cases audited demonstrate that risk assessment and specific consideration of anti-social behaviour and multi-agency involvement is happening in practice on the wards in discharge planning meetings. We have also seen how the Clinicians and Managers meeting works to embed this in routine practice.

Trust response and evidence submitted	Niche comments and gaps on assurance

• Housing advisors also visit all inpatient units every week and are able to inform the ward of any antisocial behaviour recorded by Housing Associations and complaints from neighbours. There is an Anti-social Behaviour panel in Bromley which is chaired by the local authority and attended by Oxleas staff.
• We have seen "Oxleas Care Planning Audit Results to Oct-19" which identified 91% (mean) of Trustwide service users had their risks assessed in the current episode of care, and 89% (mean) had their risks assessed within the last six months. However:
  • 63% of cases demonstrated support network involvement, and 39% of cases demonstrated that the support network had been given a copy of the care plan.
  • For Forensic services 95% (mean) of care plans addressed increased risks identified in the risk assessment with peaks at 100% of service users on three occasions.
• Between May to November 2019 there were 22 referrals for a forensic opinion where there was a concern about the level of risk, including anti-social behaviour.
• The Trust has provided a protocol for '*Request for Information made to the Public Protection Desk – Metropolitan Police*' which supports Trust staff to seek risk-based information from the police. There is a Joint Operational Protocol for Oxleas, Kent police and the Metropolitan police. The purpose of this protocol is to '*standardise the partnership response to disturbances on hospital wards or in community mental health settings that may require police attendance*'. This includes the process for monitoring. Alongside this we have seen minutes of Greenwich Oxleas Police Partnership meeting (4 November 2019) which includes details of 19 instances where service users involved were in violent incidents requiring police intervention in mental health services. We have also been provided with the minutes of the Multi-Agency Liaison Meeting Wednesday 30 October 2019 which reports on actions between statutory agencies. In the minutes provided, action was reported on S136 suites and also the roll out of SIM (Serenity Integrated Mentoring Programme). SIM London is a new programme in which a trained police officer and mental health care coordinator work regularly with service users to develop a shared care and response plan for their support and care. There is an Information Sharing Agreement in place to support in formation sharing for this initiative.
	There is clear evidence that the Trust now works in partnership with other key agencies involved (local authority, housing agency, police and CCG) with service users to ensure that there are processes in place to support the routine sharing of information regarding any potential anti-social behaviour and other risks. We have been provided with a copy of the multi-agency Information Sharing Agreement
	
	The audit demonstrates that there is a high degree of compliance with policy for risk assessments and risk assessment informing care planning, especially for forensic service users. However although there is clear evidence that for 39% of service users, support networks are routinely involved and do receive a copy of care plans this does not happen in the majority of cases and the Trust could improve this by ensuring the sharing of care plans.
	
	We have seen the evidence that SIM is in place across all three London boroughs that the Trust provides mental health services in, with copies of routine development and monitoring meetings involving stakeholders (including the Trust and the police) provided.
	
	We have been provided with redacted copies of SIM action plans which demonstrate the process is in use.

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has provided Terms of Reference for three 'High Risk Panels' (HRP), one each for Bexley, Bromley and Greenwich boroughs. A key term of reference is to "*identify individuals with a current capacity for violence and significant risk towards others, or at risk of harm from others, who require interagency collaboration to minimise and manage risk*". We have seen minutes of several HRP meetings, including one where discharge of a high-risk patient was discussed, involving several agencies as part of a wider community-based support network. Other service users discussed included people in prison and people supported in the community by various agencies. • We have seen the Information Sharing Protocol (version 2.6 May 2018) which provides the framework to safely share information about high risk individuals. • A column has been added to the weekly bed report about anti-social behaviour in the community. If a concern is noted, staff update the MDT template on RIO and adjust the care plan and risk assessment according.	We have seen strong evidence of the embedded and sustained changes to practice with the High Risk panels in place in all the boroughs, the weekly bed report, and the recent audit demonstrating risk assessments including anti-social behaviour and MDT involvement.

NIAF rating:

- The evidence reviewed demonstrates change specifically in relation to the assessment and management of risk for high risk service users. There is a clear policy which has been revised to incorporate the issues around anti-social behaviour. Practice has been audited for eight in-patient units, and demonstrates this policy is used. The RiO template facilitates the recording of family views and other agency involvement in reviews and care planning meetings. Routine Clinicians and Managers meeting demonstrate there is robust consideration of risk and discharge planning.
- We have seen evidence that there is new guidance on anti-social behaviour which has been cascaded by email and supported by a comprehensive training programme delivered via both DICES and STORM training, with inclusion of anti-social behaviour as part of the programme.
- There is robust evidence of multi agency collaboration on working with high risk service users, across all three London boroughs (Bexley, Bromley and Greenwich) and through the use of SIM with the police.
- Risk assessment has also been audited across the Trust and demonstrates a high degree of compliance. However the audit did show that involvement of support networks in the development of care plans and the sharing of care plans with support networks could be improved. However, this is mitigated by the robust processes of multiagency collaboration and the SIM working partnership with the Metropolitan police.

Overall rating for this recommendation: **5 (action complete, embedded and sustained).**

Recommendation 2: The Trust should ensure that consideration about referral to MAPPA takes place for patients with violent histories and convictions for serious violent offences. Such referrals should consider safeguarding issues and risks of domestic violence for wider family members.
NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has provided a revised policy issued August 2018 and revised August 2019 which incorporates Trust staff duties and responsibilities for MAPPA and guidance on referral process. The guidance includes discussion about domestic violence and safeguarding (children and vulnerable adults). There is an exemplar referral form which has sections to discuss risk and specific sections on safeguarding. This includes guidance issued by the London advisory group and all directorates have identified MAPPA operational leads. Cases that MAPPA do not consider requiring MAPPA involvement but are still of concern are taken to the high-risk panel that is made up of local partners including the police to ensure cross-agency working where the MAPPA model is not available (See Recommendation 1 regarding High Risk Panel). There is a flowchart to aid and guide referral. • We have seen the Trust governance structure which provides oversight of policy development. We have also seen the development and dissemination cascade and implementation of the MAPPA Policy through various meeting minutes of the Trust Mental Health Legislation Oversight Group. This was reported to the Trust Board via the Performance and Quality Assurance Committee. • MAPPA referrals and eligibility is available routinely via a report from RiO. This identifies the number of patients suitable for MAPPA and those who have MAPPA involvement and their category/level. A report from RiO April to September 2019 identified 79 services referred and 69 'outcomed' as recorded on RiO. Practice regarding MAPPA has been audited via a spot check in Sept 2019 which identified the number of service users by category and level across all three boroughs, and correlated with the RiO report. • There is good evidence of routine discussion with agencies involved concerning MAPPA for individuals via email and in care.	There is strong evidence to demonstrate policy development and roll out, with Trust oversight of this process. Practice can be demonstrated to be embedded and sustained.

NIAF rating: The evidence reviewed clearly demonstrates that there has been policy review and development to incorporate the latest guidance. Oversight has been provided and the revised policy has been cascaded appropriately.
The process of referral to MAPPA and consideration of MAPPA issues with widespread stakeholder involvement in individuals care has been demonstrated to be routine practice across the Trust.

Overall rating for this recommendation: 5 (action complete, embedded and sustained).

Recommendation 3: The Trust must assure itself that all practices of seclusion and 'de facto' seclusion on the PICU, including where patients have been segregated from others after rapid tranquilisation, are fully compliant with the requirements of the Mental Health Act 1983 (amended 2007), the MHA Code of Practice and the MHA Reference Guide.

NB: This recommendation is made to improve practice in general, and is not specifically related to his care and treatment.

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has a new Prevention and Management of Violence and Aggression Policy, issued November 2019. This has specific guidance on seclusion. There is also robust guidance on de-escalation. • We have been told there are no seclusion rooms in the Trust outside of Forensic services. • The Trust has engaged in a Quality Improvement initiative to reduce violence and aggression, and there have been very positive results. We have been provided with copies of minutes for these meetings. • Specifically on the Tarn there has been a violence reduction project, which has also incorporated Occupational Therapy as an initiative to reduce boredom and aggression. • Trust recording of violence incidents over time has shown this has had a very positive effect with a significant reduction in the number of violent and aggressive incidents on the Tarn, and a corresponding reduction in use of agency and locum staff to provide cover. • The Trust has presented this initiative at the NAPICU conference. • The Tarn has a de-escalation policy (November 2019) which minimises the use for physical interventions and seclusion. We have seen the evidence of policy development and implementation project plan. The Trust developed a 'de-escalation' room (a low stimulus room where a service user can go to calm down with staff support) on the Tarn. Since the development of the policy and violence reduction initiative, this has not been used. • Internal spot checks and external MHA monitoring via the CQC demonstrate that there has been no 'de-facto' seclusion. • There is a further initiative to support the reduction in violence, which is a pilot project for staff body worn cameras. Reports from service users show that they have felt safer when the camera's were used.	• Trust supplied evidence demonstrates that de-facto seclusion has stopped and that Trust policy is focussed on reducing violence. • Internal visits and external evidence (CQC MHA monitoring visits) demonstrates that there has been no de-facto seclusion.

NIAF rating: The evidence reviewed clearly demonstrates that there has been policy review and dissemination/implementation of the policy.
The Trust has gone further with a Quality Initiative to reduce violence.
This has included de-escalation and diversion through occupational therapy.

There is robust evidence of very positive impact for this initiative, with a significant reduction in the number of violent and aggressive incidents.
The Trust is continuing to seek ways to improve quality and reduce violence and aggression further and has piloted body worn cameras for staff involved in incidents with positive results.

Overall rating for this recommendation: 5 (action complete, embedded and sustained).

Appendix

Appendix A: Documents reviewed

Documents reviewed: Recommendation 1	
Clinical Risk Assessment Policy v1.4 Nov 2018 – please see key sections 3, 5, 7 and 13 in particular	Minutes summary ACF (PQAC and Greenwich SMT) showing governance arrangements and dissemination cascade and implementation
Embedding Learning – Guidance antisocial behaviour awareness	Minutes summary MHLOG regarding review of the terms of reference for the Bexley, Bromley and Greenwich High Risk Panels on 9.1.19 and update from the Heads of Social Care on how these had been embedded and were working effectively
Greenwich High Risk Panel Terms of Reference	RiO MDT template MH in-patients
Bromley High Risk Panel Terms of Reference	Information Sharing Agreement (High Intensity Network)
Bexley High Risk Panel Terms of Reference	Request for Information made to the Public Protection Desk - Metropolitan Police – Form
How to make a referral to the Bexley Mental Health High Risk Panel	Joint Police Protocol (under review) plus minutes to evidence how this is operationalised (Enc 13a and 13b)
Oxleas Quality Governance Structure	Independent homicide action plan progress report updated 31 Jan 2019 - showing audits – see page 2
Directorate Quality Structure linking to Trust Governance Structure Greenwich Directorate Sept 2019 – provided as an example of a Directorate quality governance structure feeding into Trust quality governance structure	Trustwide CP and RA audits
SIM London Crisis plans (names removed)	Referral data for forensic opinion by Mental Health teams

Documents reviewed: Recommendation 1 (cntd)	
Minutes of the Trust Acute Care Forum and cascaded via local Acute Care Forums (development and dissemination of Embedding Learning – Guidance Antisocial Behaviour Awareness)	email staff re circulating ASB guidance to staff.
Examples of (name redacted) High Risk Panel agenda and minutes, Terms of Reference and flow-chart.	STORM and DICES training programme outlines
Embedding Learning – Guidance antisocial behaviour awareness	RiO MDT template MH in-patients
SIM documentation including: Information Sharing Agreement, range of SIM meeting minutes within Oxleas and across the three boroughs, SIM delivery guidance (Greenwich) SIM South London End of Year report 2018-19, and Implementation of SIM London Report (June 2018)	Bromley ASB panel meeting minutes (Redacted) for 20 March 2019 and 19 September 2019
Redacted Clinicians & Managers Meetings 5 June and 3 July 2019	Bromley Acute And Crisis Care forum minutes 5 May 2019

Documents reviewed: Recommendation 2	
MAPPA Flowchart	RiO report of MAPPA
Minutes from the Trust Mental Health Legislation Oversight Group (development and dissemination cascade and implementation of the MAPPA Policy)	RiO screen shots of MAPPA active cases and recording (information anonymised) - reflecting MAPPA discussions within CPA, admission or change in circumstance such as unescorted leave for in-patients and also including out patients. Also included MAPPA levels recorded within risk assessments.
Minutes summary MHLOG regarding MAPPA	In development HRP and MAPPA Flow Chart Draft 2
MAPPA Policy v1.1 – specifically see section 3.3 and MAPPA A Form, pages 22 and 24 regarding domestic abuse	HoSC spot check September 2019 MAPPA
MAPPA Flowchart	RiO report of MAPPA
Minutes from the Trust Mental Health Legislation Oversight Group (development and dissemination cascade and implementation of the MAPPA Policy)	RiO screen shots of MAPPA active cases and recording (information anonymised) - reflecting MAPPA discussions within CPA, admission or change in circumstance such as unescorted leave for in-patients and also including out patients. Also included MAPPA levels recorded within risk assessments.
Minutes summary MHLOG regarding MAPPA	In development HRP and MAPPA Flow Chart Draft 2

Documents reviewed: Recommendation 3	
Tarn De-escalation Standard Operating Procedure	Independent MH CQC unannounced inspections issues no de-facto seclusion since 17-18).
PMVA policy v4.0 Nov 2019 – specifically see section 8.3.1, 8,4 10,4 and 10.5.	
Subsequent evidence is provided in respect of the Tarn as the recommendation was made to improve practice in general.	
Action plan for Tarn de-escalation Room SOP.	Qii Committee Minutes 27.7.19
Mental Health Act Monitoring Unannounced Visit Report – specifically page 9.	Qii Committee - Trustwide reducing violence Qi project - July 19
Tarn Qi project reducing violence and aggression presentation	NAPICU conference narrative – 2018
Summary Trustwide V & A project + Tarn data	Body Worn Camera Pilot Highlight Report 30 October 2019
Qii Committee Minutes 28.11.18	

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