Assurance review of actions taken by Barnet, Enfield and Haringey Mental Health NHS Trust following an independent investigation into the care and treatment of Mr EF

November 2021. Final report

A review of the evidence provided by Barnet, Enfield and Haringey NHS Trust that the Trust had implemented the action plan arising from an independent investigation of the care and treatment of Mr EF (published July 2017)

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Caring Solutions UK Ltd is a professional consultancy for mental health and learning disability services.

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Acknowledgements

We wish to thank all those who contributed information and evidence to enable us to complete this review.

Contributors include those who provided written information and those who agreed to a telephone conversation to clarify and confirm the documentation. We are particularly grateful to those who coordinated the provision of information and additional evidence.

All parties provided invaluable information and insights which form the basis of this report.

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1 Introduction

Background

1.1 NHS England (London) commissioned this assurance review of actions taken by Barnet, Enfield and Haringey Mental Health NHS Trust (the Trust) following the independent mental health homicide review of the care and treatment provided to Mr EF by the Trust.

1.2 The mental health homicide review was published in July 2017[1]. The review made nine recommendations for change to the practices and policies of the Trust, one of which was also actioned by NHS England. In response to these recommendations the Trust produced an action plan: we have reviewed the implementation of these actions to assess the extent to which these actions have been implemented and embedded throughout the Trust.

Terms of Reference

1.3 The terms of reference for this review were provided by NHS England, as follows:

> "We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public."

Process

1.4 The Trust sent us their action plan with evidence of completion, including embedded documents and comments as to the implementation or otherwise of the recommendations. Members of the team were sent this for comment. Two members of the team met to review this in detail and identify where we felt that additional evidence, clarification and discussion would enhance our review further.

1.5 We reviewed a number of documents and data provided:

- Action plan progress report (July 2018)

Recommendation 1

- Two documents regarding single sex accommodation

Recommendation 2

- Confirmation regarding fixed items in the garden of the acute ward

Recommendation 3

- Acute ward risk register

[1] Report of the independent investigation into the care and treatment of Mr EF

Recommendation 4

- CPA Policy
- Confirmation regarding alcohol and substance misuse in the Early Intervention in Psychosis service
- Borough reports to 'Deep Dive Meetings'[2] - Enfield, Barnet
- Update to CPA policy
- Physical Healthcare Policy, April 2016

Recommendation 5

- Minutes of contract monitoring meetings
- Service developments - Locality services for Barnet, Enfield and Haringey
- Staff consultation: Barnet Adult Mental Health Services, Locality Model
- Staff consultation: Barnet Management Infrastructure

Recommendation 6

- Confirmation regarding status of coordinator, CPA Policy
- Relevant excerpt from CPA policy
- Multi-disciplinary supervision policy for clinical and non-clinical staff, 2014
- Quality Bulletin – Care coordinator qualifications

Recommendation 7

- Risk assessment – electronic form

Recommendation 8

- Clinical risk assessment and management policy, 2015
- Confirmation regarding status of care coordinator, CPA policy

Recommendation 9

- Communication from NHS England regarding their action (currently citing, update requested)
- Internal report regarding another homicide and offers of support causing distress to staff & family; and action plan.

1.6 In addition to the information provided by the Trust, information on the Trust website was reviewed.

2 Recommendations

2.1 We made the following nine recommendations (one of which was also taken up by NHS England), arising from the findings of our review.

2.2 We were conscious that trusts are responding to recommendations for changes from a number of sources, and that this can become counter-productive. We

[2] A 'deep dive' in this context refers to in-depth and comprehensive analysis of a topic.

did not therefore replicate recommendations made by the internal report, but have added a limited number of further recommendations.

Recommendation 1:
Although we recognise that the capital implications and future plans for the site must be taken into account, we recommend that, in conjunction with its commissioners the Trust takes urgent steps to ensure that all admission wards are gender specific or, at a minimum, to create gender-specific bedroom and functional areas within mixed-sex wards.

Recommendation 2:
The Trust ensures that equipment that is currently free-standing (bench, basketball hoop) in the garden area of the ward from which Mr EF went missing is fixed to the floor. The aim is to put barriers in place, recognising that a recreational area can be high risk.

Recommendation 3:
The Trust undertakes a detailed and comprehensive audit of the safety and security of the Sussex ward.

Recommendation 4:
The Trust should ensure that all service users with psychosis who misuse alcohol and/or illicit substances are considered for referral to substance misuse services. If the decision is to not make a referral, the rationale for the decision should be recorded.

Recommendation 5:
Commissioners and the Trust consider working together to devise a more innovative, assertive outreach type of service for those service users who do not organise their lives by diaries and appointments and who move readily and frequently between organisational boundaries. Such services would be more flexible in going to service users where they are and remaining open to service users who move across team or service boundaries within the Trust.

Recommendation 6:
The Trust should follow the clinical risk assessment policy and deploy qualified staff to the CPA care coordinator role. If, in exceptional circumstances, a student is considered appropriate for the role, arrangements for role preparation (understanding of the role and appropriate training) should be made with the university programme head and include monitoring by appointed external examiners to the course.

Recommendation 7:
The Trust moves towards the development of a more personalised approach to risk assessment, which is individual to each patient, assesses current risk factors and past history and includes a management plan that follows on from the risk assessment. In the meantime, we recommend that the current training on risk assessment and guidance on the use of the existing tool is strengthened.

Recommendation 8:
The Trust should revise the CPA policy in order to ensure that the status of care coordinators is consistent with the clinical risk assessment policy.

Recommendation 9:
In future instances of homicide by a service user in contact with mental health services, and where practicable, the Trust should offer professional support to meet any mental health needs arising from the incident and should signpost families to help with any other needs arising from the incident, such as financial costs. If the victim is unknown to the Trust, a senior manager should approach the police victim liaison officer to offer assistance to victim's relatives and put them in touch with the Trust if support is requested

3 Implementation of recommendations and actions

3.1 The following paragraphs report on the information and evidence provided by the Trust and NHS England. For each action, the Trust identified the committee or group responsible for 'monitoring and evaluation' of the action. In all cases, we asked if there were any minutes or records of monitoring and evaluation by these groups. The purpose of this was to gain assurance that the Trust was monitoring the implementation of these actions at a high level of governance, and to ensure that their implementation was sustained.

Recommendation 1:
Although we recognise that the capital implications and future plans for the site must be taken into account, we recommend that, in conjunction with its commissioners the Trust takes urgent steps to ensure that all admission wards are gender specific or, at a minimum, to create gender-specific bedroom and functional areas within mixed-sex wards.

3.2 We are informed that:

a) The plans for developing new in-patient facilities on the St Ann's site include separable ends of the wards and, if they are not single sex, will follow current guidance on mixed sex wards. According to the Trust website, planning permission for the new in-patient services on the site had been approved, and work is expected to commence in early 2019 with completion by early 2021.
b) In the interim, all forensic wards are single sex; and the Enfield CD in-patient wards are single sex or have single sex areas.

3.3 Additional items in the action plan included:

a) Bed managers must check for risk or unsuitability of a particular admission environment, and escalate where concerns are identified.
b) Any reported or suspected breach is reported as an incident to the Trust and to joint meeting of the Commissioners and the Trust, and investigated.

3.4 The Trust did not provide any evidence in support of these actions, and no reference to these issues was identified in our brief review of 2018 Trust Board meeting papers.

3.5 The action plan states that the Serious Incident Review Group (SIRG), Quality and Safety Committee and Clinical Quality Review Group were involved in the monitoring and evaluation arrangements for this recommendation. The Trust informed us that the SIRG had reviewed the assurances provided but that the minutes contained no additional information. In respect of the other groups, the Trust stated that they were unsure as to how much further assurance this would provide.

3.6 We note also that the development of the new mental health in-patient to replace the existing wards at St Anne's hospital is being closely monitored by the Board and reported on the Trust website. We anticipate that this monitoring will include the establishment of single sex wards in line with current guidance on privacy and respect.

Recommendation 2:
The Trust ensures that equipment that is currently free-standing (bench, basketball hoop) in the garden area of the ward from which Mr EF went missing is fixed to the floor. The aim is to put barriers in place, recognising that a recreational area can be high risk.

3.7 The fence the patient climbed was raised promptly after the escape. All loose objects in recreational areas which could be used to assist climbing over fences/walls have subsequently been reviewed and secured. The Director of Estates and Facilities confirmed that all loose objects which could be used to assist climbing over fences or walls have been secured. A garden security checklist used on wards. The Director of Estates has visited and inspected all ward garden areas. Each ward carries out a minimum yearly risk assessment. (Further details in para 2.8)

3.8 The Health & Safety Committee was noted as being responsible for monitoring and evaluation. We asked if there were any minutes from this Committee and were informed that the trust were unsure how much further assurance this would provide to what has already been implemented.

3.9 We suggest that the substance of this recommendation (that items that could be used for leaving the wards or as weapons to use against other services users, Trust staff or visitors) is placed as a standing item on the Health and Safety Agenda.

3.10 We were invited to visit the service but felt that we were sufficiently assured that this recommendation had been implemented to make a visit unnecessary. The information provided specific to this recommendation and in relation to security more generally represent an ongoing commitment to security and safety on the wards.

3.11 Our brief review of the Board papers identified an incident which demonstrated that loose items on acute wards can be abused with serious consequences and highlights the need for risk assessment of all aspects of the environment.

Recommendation 3:
The Trust undertakes a detailed and comprehensive audit of the safety and security of the Sussex ward.

3.12 The Trust provided an example of the 12 category risk assessment that is completed by every ward / team in the trust (dated February 2018). This has categories of:

- security
- violence and aggression, and
- maintenance.

3.13 These have all been reviewed in the last 6 months. Sussex ward is officially classified as an open rather than secure ward although many of the fixtures and fittings are identical to those installed in medium secure wards i.e. windows, sanitary ware, bedroom furniture, attack alarm system etc. It has airlock doors with the final exit door controlled from reception, and it also has an internal CCTV system which is a security feature lacking in most of the forensic wards.

3.14 There is a 'security nurse 'allocated on every nursing shift whose responsibility it is to check fixture and fittings on the ward, search for prohibited items, and act as a focal point for security on the ward. The Trust report that any significant findings should be documented on the Trust's electronic systems. There is also access to 24/7 uniformed security guards who can assist staff in searching of premises, guarding of scenes or security breaches and searching for absconding patients. All nursing staff are trained in restrictive intervention techniques, and the outside exercise area has a fence of equivalent standard to a low secure forensic psychiatric ward. From time to time drugs dogs are deployed on the ward, and patients can be tested for consumption of illegal drugs when returning from leave. Security is an inherent and integral feature of the running of the ward, and issues relating to criminality are raised and discussed at regular Enfield police liaison meetings.

3.15 The Health & Safety Committee was noted as being responsible for monitoring and evaluation. We asked if there were any minutes from this Committee: the Trust did not respond to this request.

Recommendation 4:
The Trust should ensure that all service users with psychosis who misuse alcohol and/or illicit substances are considered for referral to substance misuse services. If the decision is to not make a referral, the rationale for the decision should be recorded.

3.16 Meeting the needs of service users with mental health issues and alcohol/substance misuse is included in the Physical Health Policy and the CPA policy, in respect of service users with complex needs. Both policies are robust and directive on this matter. We are informed that this is included in forms care plans for inpatients, community service users (CPA) and Early Intervention in Psychosis service users.

3.17 Compliance with care planning requirements (physical and mental health) are included in the borough 'deep dive' reports and we have reviewed reports to three of these meetings. The reports show that compliance with policy is

monitored and that actions are proposed where levels of compliance need improvement.

3.18 The Health & Safety Committee was noted as being responsible for monitoring and evaluation. We asked if there were any minutes from this Committee: the Trust did not respond to this request.

Recommendation 5:
Commissioners and the Trust consider working together to devise a more innovative, assertive outreach type of service for those service users who do not organise their lives by diaries and appointments and who move readily and frequently between organisational boundaries. Such services would be more flexible in going to service users where they are and remaining open to service users who move across team or service boundaries within the Trust.

3.19 The recollection is that the shared view at the time was that it was an isolated incident and the need for this type of model was not required based on the population need. BEH were instead asked to apply the principles of a more person-centred outreach to people with chaotic lifestyles (likened to an assertive outreach model) where required on an individual basis and as part of day-to-day community mental health teams practice. For the last five years, new investments have been agreed in conjunction with commissioners and the Trust in line with priorities set out in the mental health five year forward view.

3.20 Plans for developing a new model of service in adult mental health services (adult care pathway review) are in hand. These are to develop locality-based services for all service users. The aim of the plans is to minimise the boundaries between services and make it more likely that service users who lose contact with services can be followed up in primary care (by the new primary care link workers).

3.21 These plans are to minimise the boundaries between secondary mental health, primary care and the third sector. We recognise that this is a valuable service development and that Board papers from March, May and July indicate that this work is developing in a positive manner, including good relationships with GPs. This does not, however, appear to address the issue of service users who move in and out of boroughs, may be homeless and may not be registered with a GP or not registered in the same borough as they present when requiring special mental health services.

Recommendation 6:
The Trust should follow the clinical risk assessment policy and deploy qualified staff to the CPA care coordinator role. If, in exceptional circumstances, a student is considered appropriate for the role, arrangements for role preparation (understanding of the role and appropriate training) should be made with the university programme head and include monitoring by appointed external examiners to the course.

3.22 The Trust provided their CPA policy, which includes the statement that:

"The role of CPA care co-ordinator can only be carried out by a registered health or social care professional. While some parts of the role may be delegated to a trainee by a clinical supervisor, it will be the supervisor and not the trainee who is the named care co-ordinator, and who is responsible for ensuring that the role is carried out according to the professional standards of their professional body'."

This section of the policy goes on to set out clearly the responsibilities of the care coordinator role.

3.23 There are no plans to make exceptions to this or therefore to make arrangements with programme heads.

3.24 The policy also states that all registered clinical staff (apart from pharmacists) in both inpatient and community settings must attend CPA training; all relevant staff must attend refresher training every three years.

3.25 This amendment to the policy has been communicated to the staff - an issue of the Quality Bulletin, circulated to all staff, includes the section cited in para 3.15 above.

3.26 The action plan states that the CPA policy will include supervision arrangements for care coordinators. We also received the supervision policy – which includes all aspects of clinical practice and work with service users, colleagues and other agencies, although does not make specific reference to care coordinators or CPA.

Recommendation 7

The Trust moves towards the development of a more personalised approach to risk assessment, which is individual to each patient, assesses current risk factors and past history and includes a management plan that follows on from the risk assessment. In the meantime, we recommend that the current training on risk assessment and guidance on the use of the existing tool is strengthened.

3.27 The Trust carried out a review of national risk assessments and sought guidance from professional bodies on best practice in this complex area. They concluded that there is no national or professional consensus, and the National Confidential Inquiry into Suicides and Homicides (NCISH) is conducting research in this area.

3.28 A group was convened to review best practice in London mental health trusts to identify best practice within London: systems used by three trusts were reviewed.

3.29 As a result of enquires, the Trust concluded that there is no risk prediction tool in general use. NCISH are recommending that a checklist approach is to be avoided. The Trust currently allocates risk as 'high, 'medium' or 'low' and this cannot be justified – this will be replaced with an individualised narrative risk formulation.

3.30 The Trust decided in December 2017 to adopt that used by another London Trust on the RiO electronic clinical record system. In July 2018 it was reported that the Trust was still in consultation on this development and expects that it will be early 2019 when a new risk assessment system can be included on RiO. A template of the revised risk assessment form was provided which includes the following risk headings:

- risk of harm to self
- risk of harm from others
- risk of harm to others
- risk of accidents
- other risk behaviours (e.g. absconding)
- factors affecting risk (includes substance misuse, non-compliance with medication, disengagement with services).

After each heading there is a box for narrative risk formulation, and at the end of the form there is a box for a narrative summary. There is no space for assessment of level of risk.

3.31 We noted that the Board papers for March 2018 reported the contribution of the Trust's Medical Director to a national group reviewing risk assessment documentation, and referred to planned changes to this documentation. The Medical Director told us that he was interviewed for a report by the National Confidential Inquiry into Suicides and Safety which is now available[3], and which confirms the view of this investigation that risk gradings are not evidence-based and should not be used.

3.32 The Trust contracts risk training to external providers and confirmed that the requirement from our recommendation would be included in the procurement documentation. No supporting evidence was provided.

3.33 The Trust reported that the Trust-wide Serious Incident Review Group and Quality and Safety Group would be monitoring and evaluating the implementation of this recommendation, but did not respond to our request to provide any evidence that this had taken place.

[3] NCISH: The assessment of clinical risk in mental health services

Recommendation 8:
The Trust should revise the CPA policy in order to ensure that the status of care coordinators is consistent with the clinical risk assessment policy.

3.34 We were provided with the revised CPA policy, which included the statement cited in para 3.22 above. This very clearly aligns both policies in ensuring that care coordinators are qualified health or social care professionals and there will be no exception to this.

3.35 We were provided with reports to the three Borough Clinical Governance meetings (the 'deep dive' reports), which demonstrated that the Trust was monitoring implementation of this recommendation.

Recommendation 9:
In future instances of homicide by a service user in contact with mental health services, and where practicable, the Trust should offer professional support to meet any mental health needs arising from the incident and should signpost families to help with any other needs arising from the incident, such as financial costs. If the victim is unknown to the Trust, a senior manager should approach the police victim liaison officer to offer assistance to victim's relatives and put them in touch with the Trust if support is requested.

3.36 NHS England (London) took responsibility for one action arising from this recommendation. They have developed guidance for mental health providers and for families of victims and for families of alleged perpetrators of mental health-related homicides. This guidance is provided in the form of three information leaflets:

- Mental Health-related Homicides: Information for Mental Health Providers
- Information for Families of Victims Following a Mental Health-Related Homicide
- Information for Families of an Alleged Perpetrator of a Mental Health-Related Homicide

3.37 NHS England (London) have also completed a listening project[4] with families of victims and perpetrators as well as staff involved in investigations to seek their feedback on the process. This project resulted in four podcasts covering:

- Family members talking about the experience of an investigation from their perspective
- Family members and others talk about how best to support families
- Healthcare staff talking about the experience and the impact of an investigation on them and their teams
- Families and staff talk about how best to involve people in improving services

[4] The project was supported by Uberology, which "combines improvement science with creative thinking and a collaborative approach to deliver highly effective, solution-based programmes." Uberology

These podcasts include powerful testimonies from those most affected by mental health-related homicides.

3.38 Taken together, the information leaflets and podcasts provide a relevant and valuable contribution to supporting families and staff following a mental health-related homicide[5].

3.39 The Trust had been planning to work with the third sector and police family liaison officers to develop 'robust' processes to provide support and information, leading to the creation of joint working protocols.

3.40 After consideration, the Trust decided against this course of action on the grounds that homicide is a rare event and the circumstances of families and victims are individual to each family. They have therefore not attempted to develop a generic protocol which is unlikely to remain valid over the timescale between homicides.

3.41 An example of rather different circumstances of the homicide by a Trust service user of members of their own family is provided by the report of a Board Level Inquiry following this homicide.

3.42 Following this homicide, senior managers did approach the police victim liaison officer as recommended, to offer assistance to victim's relatives and put them in touch with the Trust if support was requested. This offer was rebuffed and led to further distress of family members and staff involved. These events were considered by the Board Level Inquiry which made further recommendations.

3.43 The specific issues identified by the internal inquiry were:

- Distress of family members at the visit by members of the community team following the homicides – they would have preferred not to meet with members of the team looking after the perpetrator
- Lack of clarity as to the reasons for the visit by both family and staff members
- Very divergent perceptions of the role and input of the police liaison officer

3.44 We agree with this panel that the Duty of Candour requires contact to be made with relatives following any serious incident, but that the manner of implementing this must reflect individual circumstances. In this later instance, the report suggests that a meeting between the agencies involved to agree arrangements for communicating with the parties might have prevented a significant part of the distress.

3.45 The report includes recommendations for joint working between the Trust and other relevant agencies to develop a Memorandum of Understanding to set out the responsibilities of the various agencies following an incident of this nature.

3.46 We would support this recommendation.

[5] The information leaflets and podcasts are available at NHS England London mental health support.

4 Conclusions

4.1 We have conducted an independent assurance review of evidence of the Trust's implementation of their actions arising from our recommendations. The Trust has provided supporting information.

4.2 Information provided by the Trust and published on their website indicates that progress is being made towards the building of new inpatient wards which will be compliant with the latest guidance on privacy and single sex accommodation. We recognise that building a new in-patient facility is a major capital development which the Trust Board will be monitoring closely. In the interim, we were assured that separate functional areas are available on wards where strict single sex separation is not yet possible.

4.3 We are assured that this recommendation has been implemented.

4.4 In relation to fixed items of furniture in the garden area of Sussex ward, we were assured that this recommendation had been implemented.

4.5 We considered that the risk register for Sussex Ward which was provided is thorough and detailed, and addresses a comprehensive list of risks relevant to this type of ward, including those identified in our investigation. In addition, the security nurse role, nurse training and ward staff access to specialist staff, if consistently implemented, should reduce the likelihood of a similar departure from the ward occurring.

4.6 We note that the Trust has gone further than our specific recommendation (in relation to one ward only), in that they report that these security measures apply to all acute wards.

4.7 We are assured that policies are in place to meet our recommendation to only allocate the care coordinator role to professionally qualified staff; and note that compliance has been monitored at the quarterly 'deep dive' meetings, with actions proposed to improve compliance where necessary.

4.8 We are informed that commissioners and the Trust have considered the recommendation that the proposal to develop a more flexible, assertive outreach style, service for service users who move around the boroughs, and that commissioners will not be progressing Current service development proposals were provided, which we considered were positive developments in terms of providing opportunities for service users who lose contact with specialist services to be followed up through primary care. It did not appear, from the information given, that this would necessarily assist service users who move between boroughs or between general practice catchment area.

4.9 We are assured that the CPA policy is now consistent with the clinical risk policy and that the policy requires that only qualified professional staff will be allocated the role of care coordinator.

4.10 Progress has been made on reviewing the risk assessment documentation and on adopting a format which would remove an assessment of levels of risk and provide for narrative formulations and summary, as recommended by NCIHS. We fully support this approach.

4.11 The Trust has provided evidence that the CPA policy is now consistent with the clinical risk policy, that those taking on the role of care coordinator will be professionally qualified, and that the borough governance committees are monitoring this.

4.12 The Trust has not implemented our recommendation for offering support to the families of victims as written and has provided a rationale for not doing so. The Trust is now considering a not dissimilar recommendation arising from a later homicide, which we would support.

4.13 With the exception of the 'deep dive' reports to the Borough governance committees, we are unable to confirm that implementation of those actions that were accepted is being monitored and evaluated. We note however that a number of committees and groups have been designated as monitoring and evaluating the implementation of these recommendations, and we note the responsibility and accountability of these structures.

4.14 Overall, we conclude that the steps taken by the Trust in response to our recommendations should help to reduce the likelihood of an event such as the death of Mr AB happening in the future. These steps should strengthen the barriers which minimise human errors in the delivery of mental health care and treatment.

4.15 Where further steps are to be taken as part of organisation development, we note it is intended these will reflect the need to overcome the weaknesses which the review and similar ones have identified post serious incidents.