Independent Investigation - Action Plan
Published: November 2021
STEIS Ref 2015/37484

Statement from Barnet, Enfield and Haringey Mental Health Trust:
The Trust would like to offer a sincere apology following the incident which has led to severe injuries to the victim. Following recommendations made by an external investigation in 2016, the Trust has taken action to make changes to our practice and embed what we have learnt across the organisation. The delivery of these actions is monitored by the Trust Board and has also been reviewed by NHS England. We accept the recommendations of the independent investigation report in full and are committed to continuing to improve our practice. While we fully understand that this will not lessen the serious impact of this incident for the victim, we hope that this provides assurance of our commitment to learn following this incident. As a Trust we continue to strive to improve practice on a continuous basis.

Statement from NHS North Central London Clinical Commissioning Group (NCL CCG)

Until 31 March 2020, Enfield Clinical Commissioning Group (CCG) was the lead commissioner responsible for the commissioning of health services from Barnet, Enfield and Haringey Mental Health Trust (BEH MHT), for the local population and surrounding boroughs. On 1 April 2020, the five CCGs across North Central London (including Enfield CCG) merged and North Central London CCG was established.
NHS North Central London CCG is deeply saddened by this tragedy and our thoughts are with Mr A and his family. We are working with Barnet, Enfield and Haringey Mental Health NHS Trust to ensure that lessons are identified and learnt to prevent an incident like this happening again. We hope that this report reassures Mr A and his family that we are acting on all the lessons learnt from this review of the care and treatment of Mr G.

Rec No.	Organisation	Recommendation	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
1	BEHMHT	The Trust should assure itself that it has the appropriate mechanisms in place to formally monitor the ongoing application of CTOs and document any decisions and MDT involvement pertaining to changes in their management (e.g. removal).	a. Trust has up to date policy in place against which audits are completed b. Regular audits of Community Treatment Order (CTO), incorporated into the trust Care Programme Approach (CPA) audits	Medical Director	a. CPA Policy reviewed and updated 2017 b. Barnet has completed regular CTO audit - August 2019 c. Trust wide CPA audits - Ongoing d. Trust working towards introducing Dialog Plus Care Planning - aim to produce robust co-production in care planning; 2020	**COMPLETED** • Care programme approach (CPA) policy revised August 2017; available to all staff via Trust intranet • Community Treatment Order (CTO) Audits in place - twice yearly. Audit outcomes monitored at Mental Health Law Committee (MHLC), sub-committee of the Board. MHLC is responsible for overseeing any actions. • Trust wide CPA Audit reports monitored by MHLC and Divisions • Announced Care Quality Commission (CQC) inspection in 2017 of CTO use in Haringey found good evidence of patient involvement in the discharge planning process. • Multi-disciplinary supervision policy for clinical and non-clinical staff revised in April 2019, available to all staff via Trust intranet. Policy supports structured discussions about specific service user care.	Audit results go to the Trust Clinical Audit & Effectiveness Committee which reports to the Safety, Effectiveness & Experience Group (SEEG) which in turn reports to Quality & Safety Commttee which is a sub committee of the Trust Board Audit results are reviewed at Team and Divisions governance meetings
2	BEHMHT	the Trust should develop a forum in which different community teams are able to meet, share experiences and best practice.	a. Complete organisational re structure from Boroughs to Divisions with senior management restructure to strengthen pathways across trust b. Leads in post across pathways of care c. External review of governance structures, recommendations being finalised. d. Shared Learning a priority workstream for the trust (Brilliant Basics; priority workstreams qualitative improvement programme) e. Crisis Collaboration meetings	a.Executive Directors b. Director of Nursing lead for the Brilliant Basics Programme	a. Organisational restructure to Divsions completed October 2019. b. Leads in post October 2019 c. Governance structures in place October 2019 d. Brilliant Basics porgramme commenced April 2018 and on going e. Shared learning occurs in many ways inclusive of: network meetings Quality Bulletin - sent to all staff Blue Light Bulletins for urgent learning Patient Safety Conference Berwick Events	**COMPLETED** • Divisional quarterly Deep Dive meetings were in place 2016 - 2019 attended by all community and inpatient teams. Good practice, learning and experiences shared across teams. • Trust has completed restructure from 4 Boroughs to 5 Divisions to strengthen management, governance and patient pathways. • Pathway leads in post; regular meetings of pathway leads in place. • Governance Committee structure revised following Independent review. First committee meetings held October 2019, attended by community and inpatient representatives. • Brilliant Basics (BB) programme in place with 10 priority workstreams applicable to all Trust services: - Shared Learning - Physical Healthcare Monitoring - Mandatory Training - Recruitment & retention - Restrictive Practices - Risk Assessment & care planning - 132 rights - Safe Environment - Data - Ward to Board - Access to Beds Workstreams use Quality Improvement methodology. Progress monitored at monthly Trust BB meeting. Representatives covering both community and inpatient areas attend monthly BB meetings; information, practice and experiences shared with all teams. Quality Improvement project led by the multi-professional Shared Learning Collaborative commenced in 2020 to improve learning across Trust services and Divisional teams commenced in 2020. Work underway with Safeguarding, Patient Experience and Patient Safety Teams to review exisiting processes and accessibility of information by all staff groups, and to implement change where required to ensure maximum opportunities for learning exists across the Trust.	Executive Team have accepted the external governance review by Deloittees and the management and governance structural changes. Brilliant Basics workstreams have an Executive Sponsor with operational leads who each have set up their committee and groups to adress their priorities - these feed into a monthly Brilliant Basics meeting chaired by the Director of Nursing and a report is sent to the Quality & Safety Committee ,a sub committee of theTrust Board. The CQC in its recent Well Led Inspection sited as outstanding practice The crisis teams came together each quarter and formed the 'crisis collaboration'. This was a partnership with each crisis team to share best practice and offer informal training to support staff in areas their team performed well in.
3	BEHMHT	the Trust Medical Director should ensure the revised risk assessment template draws on existing good practice in place at other mental health trusts and is available to staff within the next three months	Trust wide working group led by Medical Director - review the risk assessment in use Develop comprehensive risk assessment New form agreed for IT RIO system - system used for patient records Training on new risk assessment Risk Assessment is one of Trust's Brilliant Basic workstreams	a. Executive Medical Director b. RiO Steering group c. Executive Medical Director d. Deputy Director of Nursing e. Deputy Director of Nursing f. Deputy Director of Nursing	a. Risk Assessment conference b. Agreed form on RIO C. Written standard for completion of risk assessment d. Policy for clinical risk management updated and in use e. training programme in place f. audit programme for risk assessment in place March 2020	**COMPLETED** • Following collaborative work with pan-London NHS Trusts, a risk assessment tool based on good practice was developed and adopted by BEH. • BEH clinical risk training developed and rolled out. Risk assessment tool went live in November 2019. • Brilliant Basics - Risk Assessment and care planning workstream in place, leading work across the trust to improve the quality of risk assessments and care plans and to ensure every service user has an updated risk assessment every six months and/or updated after an incident occurs. This work is ongoing. • Risk Assessment are audited monthly across all clinical services> Audits are monitored via Divisional Governance meetings, and Trust Safe, Effectiveness and Experience Group (SEEG).	Brilliant basics - Risk Assessment and care planning workstream
4	BEHMHT	Side effect monitoring should be regularly undertaken and assessed as part of the care plan in place	Pharmacy Audit - assessing the side effects of Depot Antipsychotic medication (POMH-UK- Topic 6d). Medicine Management Policy (Section 18.8) states "The monitoring of the service user for reported medicines-related adverse effects should be included in the care plan for any service user who is prescribed medication." Physical health Policy (Section 7.7) states "Medical Staff are responsible for an in-depth, history, assessment and examination of a service user's health and the assessment which includes "Record of all currently prescribed medication and adverse reactions to past medications (RIO – Physical health history). For service users on antipsychotics the examination should specifically include an assessment of side effects. A standard rating scale such as GASS or LUNSERS should be used as part of the assessment and uploaded onto RIO."	Trust's Chief Pharmacist Physical Healthcare Group	BEH Pharmacy Audit - external parameters set and NICE Local protocol upon request or minimal standards (CPA- 6 monthly, Care management - yearly) (Ad Hoc)	**COMPLETED** • (POMH-UK- Topic 6d) annual audit report 2019: 93% of the patients at BEH had documented evidence in their clinical records of assessment of side-effects in the last year. • Physical Health Policy - revised and implemented since incident. • Monitoring of side effects is part of day-today clinical practice. If clinician requires support in addressing side effects it can be addressed via supervision or in discussion with pharmacist.	POMH-UK Audit results go to the Trust Clinical Audit & Effectiveness Group which reports to the Safety, Effectiveness & Experience Group (SEEG) which in turn reports to Quality & Safety Commttee which is a sub committee of the Trust Board Audit results are shared with and reviewed at Team and Divisions governance meetings. Care plans and monitoring of physical health reviewed as part of Trust audit programme. Shared/monitored as above.

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5	BEHMHT	The Trust should review its communication processes between Inpatient and Community teams with a view to ensuring care coordinators are told in a timely manner of patients' discharge from the ward.	Care Programme Approach (CPA) Policy in place	Medical Director	a.Completed 2017 b. Discharge Policy review and updated - January 2020	**COMPLETED** • CPA Policy revised in August 2017 and implemented. Policy sets out the processes to be followed when discharging patients who require CPA from hospital, and the need for communication with community care co-ordinators. • Discharge Policy, revised February 2020 specifies that care co-ordinators must be involved in all formulation meetings. • Audit by Access and Flow team of Pride and Joy (Bed management) system and formulation meetings. All delayed discharges are reviewed on daily basis. • Ongoing monitoring of complaints and incidents in relation to this - addressed via Divisional Management Board. • Access to Beds Brilliant Basics workstream • Policy are reviewed by the relevent specialist group for approval before being ratification at the Trust Policy Review Group. Following this, the policy will go onto the Trust's intranet, and is highlighted in the BEH Bulletin and relevant staff forums for awareness.	Audit results go to the Trust Clinical Audit & Effectiveness Committee which reports to the Safety, Effectiveness & Experience Group (SEEG) which in turn reports to Quality & Safety Commttee which is a sub committee of the Trust Board Audit results are reviewed at team and division governance meetings.
6	BEHMHT	The Trust should evaluate the role of GP link workers with a view to ensuring community staff and GP surgeries are confident the role is achieving its remit and facilitating stronger relations between both groups.	a. Division to hold quarterly meetings with their CCG. B. To discuss and agree GP representative to attend team meetings	Division Clinical Director	a. Barnet completed b. 01/04/2020	**COMPLETED** • Barnet primary care link working team, otherwise known as Barnet Transformation Adults Team has been in existence since 2016. The team is commissioned by Barnet CCG to work with Barnet GPs to bridge the gap between primary care and secondary care services in context of ensuring prompt services for clients who may be in need of psychiatry services. • Link working team remit includes review of GP referrals and ensuring onwards referrals to community mental health teams or other community agencies where clients' needs could be met promptly. Additionally, they process referrals from the police, MASH and social services. Ongoing evaluation and monitoring of the link worker role. • Planned transformation of community mental health teams in 2021 - to have appropriately resourced team in each Primary Care Network i.e. Place-based care. • All community mental health team caseloads were reviewed to understand which client requires further and immediate support from the team.	Barnet Governance and operational meeting minutes - report to Trust Operational Group Meeting which reports to Executive Level Team (ELT)
7	BEHMHT	The Trust must update its Discharge/Transfer policy and procedure.	The Trust will review and update its Discharge/Transfer Policy within three months	Urgent care Service Manager (including liaison) Barnet Borough Adult Mental Health	Jan-20	**COMPLETED** Policy approved February 2020 and available on trust intranet and cascaded to all staff via bulletin.	Policy Review Group - which reports to Quality & Safety Committee, a sub committee of the Trust Board will track progress
8	BEHMHT	The Trust should review the tools and processes available to support staff working with families who do not endorse clinical decisions and may be reluctant for their relative to take medication. In particular concerns and information about side effects, side effect monitoring and documentation of those discussions	The trust will implement suitable support mechanisms for staff who work with families in relation to care and treatment plans.	Psychology Lead Patient Safety Team	Mar-20	**COMPLETED** • Introduction of Open Dialogue which involves training healthcare staff in family therapy and psychological skills, to enable to work with the whole family, encouraging involvement of families. It is a very transparent approach to looking at issues. • Clinicians use their team meetings, reflective forums, supervision and peer groups to gain support and suggestions around how best to work with these patients and their families. Clinicians will be considering legal and ethical issues in the areas of capacity, confidentiality, competence and minimising harm, respecting autonomy and fairness. • Community (ward) meetings open to carers and family members in place across all teams. Meetings provide carers with an opportunity to raise issues. • The Trust promotes a holistic and Think Family approach with consideration of individual needs. • High Dose Monitoring form and policy in place. Monitored by Pharmacy and advice provided to staff where necessary. • System in place for staff to check with pharmacy, patient leaflets and to discuss in weekly safety huddle - well established for every team to receive senior support. • New Servic User Involvement and Engagement Strategy developed and designed by service users, launched September 2020. The strategy outlines the importance of actively involving service users, their families and carers in shaping, delivering and evaluating their care. • Monthly Patient and Carer Satisfaction survey data sent to Divisions to review and action where necessary; data monitred at monthly Safe, Effective and Experience Group.	Care Plan Audit outcomes go to the Trust Clinical Audit & Effectiveness Group which reports to the Safety, Effectiveness & Experience Group (SEEG). Clinical supervision and safety huddle meetings to track that support is being provided where required. Pharmacy to report any concerns in relation to high dose medication through Medicine Safety Group which reports to SEEG.
9	BEHMHT	The Trust should prioritise psychological therapy for high risk patients likely to benefit from it	Trust wide Working group set up to establish uniform data systems to evaluate, scope and collect data on waiting lists -Examine the model of delivery for types of waiting lists and therapies – define and implement a standardised approach to the pathways -Examine the structure and processes to enable monitoring and managing of waiting lists -Demand capacity modelling – workforce capacity, how is this measured against service user throughout	Trust Lead Psychologist	November 2019 January 2020 January 2020 March 2020	COMPLETE • In-depth project to review waiting list for psychological therapy, to assess and prioritise patients waiting for treatment undertaken in response to CQC recommendation The trust should continue to improve waiting times for patients to access psychological interventions, and ensure that patients are safely monitored whilst waiting for the interventions. Action completed and closed by Board. Three phases of project: - Review of Productivity/demand and capacity - Defining the measure of waiting lists - Interventions to reduce waiting lists • Trust wide psychological therapists group established • Standardised productivity set in terms of contacts per staff group • Trust dashboard in development to record waiting times for assessment and from assessment to treatment. • Waiting list review undertaken every 3 months. Data reported to Board via the Intergrated Performance Report. • Model of delivery for types of therapies reviewed – standardised approach to the pathways defined and implemented. • The Trust commissioned an independent psychological review in2018. Recommendations have been implemented.	The trust wide working group will report to the Trust Operational Management Group (TOMG)
10	BEHMHT	The Trust should ensure all key stakeholders - including any victim of a patient related serious incident - have an opportunity to review and comment on a draft investigation report in advance of sign off.	a) BEH to provide evidence of completion of action plans to Enfield CCG in the quarterly CCG, CSU and Trust SI panel meeting. b)BEH to provide Enfield CCG historical high risk and Board SI reports and provide assurance on the completion of action plans c) Attendance at BEH Serious Incidents Review Group agreed with Enfield CCG and NEL	Deputy Director of Quality Governance	a) Completed September 2019 b) January 2020 c) Bi-monthly (next meeting November 2019 and bi-monthly d) Monthly BEHMHT CQRG meetings - next meeting 31st October 2019	**COMPLETE** • Link with NHSE project on family engagement and working with police. • BEH link worker actively with Victim liaison officer (VLO) nominated by Court to understand and address current and ongoing issues. • Quality improvement project implemented by the Patient Safety Team in 2020 promotes involvement of all those involved in an incident, in the investigation and report review process. As part of new process, a Family link worker role is being developed to ensure the Trust considers the victim and does right by them. • Duty of Candour processes are in place. Compliance with Duty of Candour is reported by the Divisions monthly to the Patient Safety Incident Review Group, chaired by the Medical Director and monitored by the monthly Safe, Effectiveness and Experience Group.	Divisional SIRGs Trust SI Assurance Group

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11	BEHMHT	The Trust should review its processes for engaging with third parties* affected by the actions of its patients, with a view to ensuring a comprehensive and supportive communication pathway. * people not treated by the Trust but who have had their lives impacted by the actions of those receiving treatment from the Trust, for example, families of homocide victims	a. Trust Management of Incidents Policy - to be reviewed and aligned to the new NHSE Patient Safety Incident Response Framework. b. Contact neighbouring organisations to review how they engage victims of crime by their patients so lessons can be learnt	Head of Effectiveness	Trust Management of Incidents Policy updated September 2019 and Sept 2021	**COMPLETED** • Trust Management of Incidents Policy stipulates that engagement with and support to victims of incidents must be considered. Policy references guidance from NHSE on supporting family of victims and perpetrators of incidents. Critical Incident Support Framework (Supporting staff and teams following a critical incident) added to policy. • Duty of Candour regulation does not apply to third parties. New NHSE Patient Safety Incident Review Framwork in development stipulates necessity for Trusts to ensure they are doing the right thing by third parties.	Divisional Management teams Divisional SIRGs SEEG
12	NHSE	NHS England should review the national guidance in place to support the victims of serious incidents and mental health homicides, to develop a strategy to ensure health and social care providers offer appropriate support and engagement as required, both for recovery purposes and assurance that improvements have been identified and implemented.	A) NHS England to develop collaborative guidance/podcasts with families and key stakeholders on supporting families following a mental health homicide. B) Support guidance and podcasts to be published on the NHS England website C) Support guidance and podcasts to be provided to providers and commissioners of Mental Health services D) To include guidance on supporting victims of serious incidents and mental health homicides within the draft Patient Safety Incident Response Framework	Patient Safety Lead Mental Health, NHS England and Improvement, London	A, B and C) Completed May 2019 D) Completed September 2019	A, B and C) published May 2019 materials can be accessed via: https://www.england.nhs.uk/london/our-work/mhsupport/ May 2019 launched guidance at Mental Health Patient Safety - Assessing and Managing Risk conference in London D) Incorporated guidance by the Head of Patient Safety Investigation, NHS England and Improvement.	Regional monitoring via Independent Investigations Review Group National monitoring via the Independent Investigation Governance Committee
13	BEHMHT	The Trust must provide an evidence based review of its action plans to the CCG with a view to it being signed off within three months	As per action 10: a) BEH to provide evidence of completion of action plans to Enfield CCG in the quarterly CCG, CSU and Trust SI panel meeting. b)BEH to provide Enfield CCG historical high risk and Board SI reports and provide assurance on the completion of action plans c) Attendance at BEH Serious Incidents Review Group agreed with ECCG and NEL	Deputy Director of Quality Governance	Ongoing	**COMPLETED** • All serious incident investigations sign off by BEH Medical Director and CCG. • Monthly Divisional reports to the Patient Safety Incident Review Group and Safe, Effectiveness and Experience Group (SEEG) include action plan status. SEEG will provide exception report to the Quality & Safety Committee, a sub committee of the Trust Board. • Quarterly meeting between the Trust and CCG where actions plans are reviewed and monitored and evidence provided as required. Formal review of the Trust's action plans from all Board Level Panel Investigations, including homicides initiated by the CCG in February 2020. This review is ongoing.	Monitoring at fortnightly Patient Safety Incident Review Group and monthly SEEG.
14	BEHMHT	The Trust should assure itself as a priority that it has correct systems and processes in place to monitor and implement action plans, and that it maintains audit trails of actions implementation.	Patient Safety Team will ensure SI and BLPI reports and action plans are on divisional governance meeting agendas. Patient Safety Team will send monthly reports and outstanding actions plans to Safety, Effectiveness and Experience Group (SEEG).	Head of Effectiveness	Ongoing	**COMPLETED** • Independent review of Trust governance processes undertaken in 2018-19. New Governance structure implemented October 2019. • Monthly Divisional reports to Safe, Effectiveness and Experience Group (SEEG) reports to include action plan status. SEEG will provide exception report to the Quality & Safety Committee, a sub committee of the Trust Board. • Exception report provided fortnightly to the Trust Patient Safety incident Review Group	Monitoring at fortnightly Patient Safety Incident Review Group and monthly SEEG.
15	Enfield Clinical Commissioning Group (ECCG)	The CCG should review itself as a priority that it has the correct systems and processes in place to gain timely assurance of the robustness of Trust investigation reports and action plans.	1. Review of; a) NCL CCGs Serious Incidents panel Terms of Reference b) BEH MHT, Enfield CCG, NEL CSU quarterly SI panel Terms of Reference c) NEL CSU Patient Safety Team & NCL CCGs Service Level Agreement d) NEL CSU Patient Safety Team SI Trend and performance reports including KPIs e) NEL CSU Patient Safety Team Mental Health quarterly report	Enfield CCG Director of Quality and Clinical Services	a) Completed June 2019 b) Completed June 2019 c) Completed April 2019 d) On-going e) December 2019	• NCL CCGs SI panel Terms of Reference & meeting minutes • BEH MHT, Enfield CCG, NEL CSU quarterly SI panel Terms of Reference & meeting minutes • NEL CSU Patient Safety Team trend and performance reports including KPIs • NEL CSU Patient Safety Team & NCL CCGs Service Level Agreement (SLA)	NCL CCGs monthly Serious Incidents (SI) panel BEH MHT, Enfield CCG, NEL CSU quarterly SI panel BEH MHT CQRG monthly meetings Annual SLA review meeting
16	Enfield Clinical Commissioning Group (ECCG)	The CCG should assure itself as a priority that it has the correct systems and process in place to be assured Trusts are implementing action plans, and that there are no other historical cases in which action plan assurance has not been sought and provided, specifically for high risk and Board level cases.	a) Enfield CCG to request evidence of completion of action plans from BEH MHT in the quarterly CCG, NEL CSU and Trust SI panel meeting. b) Enfield CCG to request from BEH MHT a review of historical high risk and Board SI reports and provide assurance on the completion of action plans c) Continually strengthen the relationship and quality assurance processes in place between Enfield CCG, BEH MHT and NEL CSU via collaborative formal and informal meetings d) Any issues identified to be escalated to the BEH MHT CQRG	Enfield CCG Director of Quality and Clinical Services	a) Completed September 2019 and ongoing b) Completed February 2020 and ongoing. Review to be finalised by end of March 2021. c) Completed and ongoing d) Monthly BEH MHT CQRG meetings	• e-mail correspondence between Enfield CCG, NEL CSU Patient safety team & BEH MHT • BEH MHT, Enfield CCG, NEL CSU quarterly SI panel Terms of Reference & meeting minutes • Enfield Quality team invited to review and comment on recommendations made in the BEH MHT Quality Improvement SI programme (July 2020) • BEH MHT CQRG Meeting Minutes	• BEH MHT, Enfield CCG, NEL CSU quarterly SI panel meeting • BEH MHT CQRG Meeting

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17	Enfield Clinical Commissioning Group (ECCG)	The CCG should assure itself as a priority that Trusts respond to commissioner concerns regarding investigation reports and action plans, and do not sign off reports in advance of the CCG quality assurance process.	a) Enfield CCG, BEH MHT and NEL CSU patient safety team have agreed process for the submission of draft Board Level SI reports to NEL CSU patient safety team before sign off	Enfield CCG Director of Quality and Clinical Services	a) Agreed and completed with recognition on-going process for future reports 24.09.19	• e-mail correspondence between Enfield CCG, NEL CSU Patient safety team & BEH MHT • BEH MHT, Enfield CCG, NEL CSU quarterly SI panel Terms of Reference & meeting minutes • Board Level SI report quality assurance comments	• NCL CCGs Serious Incidents (SI) panel • BEH MHT Enfield CCG, NEL CSU quarterly SI panel • BEH MHT CQRG

Acronyms:

NCL - North & Central London
BEH MHT - Barnet Enfield & Haringey Mental Health Trust
NEL CSU – North East London Commissioning Support Unit
SI – Serious Incident
CQRG - Clinical Quality Review Meeting
SEEG - Safe, Effectiveness and Experience Group