PSYCHOLOGICAL APPROACHES CIC

INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Mr X 2017 (6089)

Review of recommendations & action plan following the report presented in January 2021

JUNE 2023

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Process for this review

1. After internal review and accuracy check, the final report was provided to NHS England/NHS Improvement (Midlands & East of England) in January 2021.

2. A pre-publication meeting (delayed due to the challenges of the pandemic) was held with all stakeholders on the 21/11/21.

3. In liaison with the Psychological Approaches team, NHSE requested a follow up review of the implementation of the recommendations and action plan in November 2022.

4. Psychological Approaches have since been in regular dialogue with the lead provider, Derbyshire Healthcare NHS Foundation Trust, seeking information to demonstrate evidence of progress against the recommendations and action plan. This was provided on the 29/3/23.

5. On 25/4/23, a meeting was held on Microsoft Teams to seek further assurance of progress, and in May 2023 the Trust provided further evidence to demonstrate their implementation of the recommendations. The evidence provided by the Trust from March to May 2023 is listed in Appendix 1.

Brief summary background

6. Mr X was living in a 2 bedroomed house provided by Derventio Housing Trust, a large provider of supported accommodation in and around Derby. In March 2017 Mr X stabbed his housemate causing fatal injuries to the face and neck. Emergencies services attended but the victim was pronounced life extinct at the scene.

7. Mr X told the officers that he had killed the victim because he had stolen from him. He offered no resistance to arrest and asked if mental health services could be informed as he was under their care (Derbyshire Healthcare NHS Foundation Trust), saying he was on anti-psychotic medication. Mr X was arrested and taken into Police custody.

8. In September 2017, he was convicted of manslaughter on the grounds of diminished responsibility and received a Section 45 Mental Health Act (Hybrid Order) with secure hospital treatment and prison sentence (life imprisonment). He is to serve a minimum term of 6 years before he will be eligible for parole. He was transferred to Wathwood Hospital, (MSU) where he will remain until such a time that he is deemed well enough to move back into the prison population.

Terms of Reference for the Independent Investigation - JE 2017/6089

9. The terms of reference (ToR) of the independent investigation were set by NHSE and agreed with all stakeholders. Full terms of reference can be seen in the original report.

Conclusions of original investigation

10. The independent reviewers were unanimous in concluding that the homicide was not a predictable outcome. Based on Mr X's history, the risks of a deterioration in his mental state included a relapse into substance misuse and disengagement with services.

11. The final report addressed each of the ToR separately, providing comment and conclusions on each, before providing a brief concluding statement and three principal recommendations. These are included here, together with the evidence provided by the Trust to demonstrate their progress in implementing the recommendations through their subsequent action plan.

Recommendation 1 (from January 2021)

12. To implement effective multi-agency management of patients that may present long-term risks.

13. The legal framework of a Community Treatment Order exists to support patients who are discharged from hospital and living in the community. In this case the responsibilities lay with Derbyshire Healthcare NHS Foundation Trust (the Trust), NHS Derby and Derbyshire Clinical Commissioning Group and Derventio Housing Trust.

14. The panel recommend an inter-agency collaboration facilitated by NHS Derby & Derbyshire CCG, with representation by a senior clinician and senior manager from the Trust and a senior case worker and senior manager from Derventio Housing Trust and other organisations with a stake in housing service users such as Mr X.

15. The expected outputs should include a quality improvement programme to:

- Produce, implement and monitor an agreed protocol for interagency working.
- Analyse systemic factors impeding joint working and address these, including the use of software for remote working, which has become common practice.
- Focus on risk management and information sharing, with particular relevance to times of transition between levels of care.
- Agree a process for ongoing monitoring and reporting to ensure progress is maintained.

Evidence demonstrating implementation of Recommendation 1

Draft document entitled "Interagency working – multi-agency management of high-risk individuals" (January 2022).

16. This was viewed by the investigators as a positive strategic document, supporting the aspiration of interagency working. At the meeting of the 25/4/23, the investigators were informed that this document has now been ratified and gone live. Its current focus is on working age adults. As it is in the early stages of implementation, no audits have yet been completed, but these are planned.

The document includes a multi-agency check list (but currently no examples have been seen).

Minutes of the "Reducing Offending/Reoffending and Offender Health Board" (18th October 2022).

17. The focus of the meeting was primarily on the Criminal Justice System. However it was recorded that some mental health training has been provided to reactive officers and custody officers. On the 25/4/23, it was stated that this was provided by the Liaison and Diversion Team. In addition the investigators were informed that the MH Community Team are doing "cross-training" with other agencies.

Document provided by the Trust, "Independent Enquiry action plan – March 23 JE STEIS Ref: 2017/6089"

18. This states that the Trust has fully embedded Microsoft Teams and 'Attend Anywhere' software. The independent investigators have seen this in recent meetings held using the Microsoft platform. The Trust have provided the Clinical Video Calls Policy and Home Working Policy as evidence.

Extracts from a meeting of the "Interagency collaboration meeting re Housing + Forensic mental health group".

19. This describes the allocation of social workers to acute mental health wards to undertake the needs assessments and also allocation into community teams for ongoing support as part of an individual's discharge plan. It was confirmed that these social workers were now in post at the meeting on the 25/4/23, but they are employed directly by the local authorities and have since been removed. The Trust still has some social work input for each unit, these social workers are invited to ward rounds and rapid reviews. They are also part of early discharge planning meetings.

20. The independent investigators noted that a multi-agency Section 117 Policy and Framework was in place which clarifies the role of multi-agency communication and working. It is a requirement to agree a multi-agency care plan before a patient is discharged. The Trust have provided the Living Well SOP and the FCMHT audit summary from April 2023.

The Trust's Standard Operating Procedure for Forensic Community Mental Health Teams

21. This describes the case management of a defined caseload of patients in the community, who present a significant risk of serious harm to others related to their mental disorder, particularly those leaving secure care. The investigators asked if this document was now live, as it was identified as a "Draft 2019" and issued Trust wide in January 2020, with a review date set for January 2023. We were informed at the meeting on the 25/4/23 that this had in fact been ratified the previous week. The Trust have provided the FCMHT Operational Policy

(reviewed January 2023) plus a redacted MDT care plan as supporting evidence.

22. The important role of audit was mentioned within this document (paragraph 17), and the Trust confirmed that a number had been carried out. They shared the FCMHT audit summary from April 2023.

Trust Patient Safety Team Dashboard

23. To demonstrate the ongoing monitoring and reporting of progress in relation to this investigation, the Trust has set out the document "Independent Enquiry action plan – March 23 JE STEIS Ref: 2017/6089". The investigators were given verbal assurance that the Trust's patient safety team has oversight of this which is reported in the form of a dashboard. The Trust provided the Actions Monitoring Process following completion of iinternal/external investigations. This demonstrates actions associated with allocating responsibility for patient safety, monitoring and improvements. Further, the Trust is developing a governance group for embedding learning and service improvements following incidents. Draft TOR for this group (yet to be named) were provided.

Conclusion – Recommendation 1

24. The investigators have agreed that the requirements of Recommendation 1 have been met and that processes are in place for ongoing monitoring.

Recommendation 2 (from January 2021)

25. To review and standardise the role of the Care Co-ordinator. A quality improvement programme around this role should be developed to promote good practice. The following should be included:

- An analysis of systemic factors impacting on the care co-ordinator role and addressing these.
- The identification of a named individual to provide practice leadership and head the production of a development programme for the care-coordinator role. This could include the audit of care plans and the use of templates.
- The inclusion of service user and carer input into the development programme.
- Ensuring that knowledge and skills matches service user complexity and acuity, including working proactively with psychosis and dual diagnosis and an emphasis on empowerment and self-care.
- Multi-disciplinary input to develop and implement clinical formulations for all service users.

Evidence demonstrating implementation of Recommendation 2

Relevant information from the "Independent Enquiry action plan – March 23 JE STEIS Ref: 2017/6089"

26. This stated that "Co-development work was undertaken during 2021 in relation to the role of the Care Coordinator including training needs. A training and

development support package has been developed including an outline version of the curriculum and competencies. This was submitted to HEE 2021."

27. The Trust confirmed verbally that a training package has been established, and that it is monitored.

28. The Trust also confirmed that that the Head of Nursing for Community Mental Health has oversight of audits, deficits in learning and provides line management to the Community Mental Health Tutor with the Education team.

Appointment of a Clinical Educator -Community Mental Health Division

29. This was described in Appendix 3 of the "Forensic Community Mental Health Team Standard Operating Procedure". The investigators were pleased to learn that an individual was appointed and took up this role in January 2022.

Development and Training for Care Co-ordinators

30. The "Independent Enquiry action plan March 23 JE STEIS Ref: 2017/6089" describes that co-development work had been undertaken during 2021 in relation to the role of the care co-ordinator including training needs. A training and development support package has been developed including an outline version of the curriculum and competencies. This was submitted to HEE in 2021.

31. Further, with the development of the Forensic Community Mental Health Team, care co-ordinators within this service receive additional training and support which includes HCR20, dietetics, MAPPA and form part of a Multi – Disciplinary/ Professional team. The Trust provided verbal assurance of this training. The investigators were informed that some staff in the Community Forensic Mental Health Team had received training about the role of the Social Supervisor.

A Protocol for forensic clinical supervision. (Draft document)

32. This protocol described that a recent independent investigation had identified that Derbyshire Healthcare Foundation Trust Forensic Community Mental Health Team (FCMHT) should ensure that effective supervision structures are in place. In the meeting of the 25/4/23, the Trust confirmed that the process referred to in the above document was now live. However, currently only paper records are held.

33. The Trust have shared the supervision policy which is specific and identifies the process for escalation of clinical concerns. The Trust further commented that forensic supervision complements clinical supervision, and that the Forensic Team has a multi-professional meeting now each week.

34. Further, the 'Independent Enquiry action plan (1) March 23 JE STEIS Ref: 2017/6089' states that "supervision processes include caseload discussions

and clinical caseload supervision, including an awareness of the potential impact of the client group on staff and the public”. In the meeting of the 25/4/23, verbal assurance was provided that Clinical supervision and managerial supervision are monitored via the Trust training/supervision dashboard. The meeting further confirmed that in relation to Restorative Supervision, three nurses have undertaken the Professional Nurse Advocate (PNA) training which was launched in March 2021 and is therefore still in its infancy.

Conclusion – Recommendation 2

35. The investigators have agreed that the requirements of Recommendation 2 have been met and that processes are in place for ongoing monitoring.

Recommendation 3 (from January 2021)

36. To consider the need for development of a dedicated community forensic team and high support hostel for the population of Derbyshire. This would be informed by a needs analysis of the current Derbyshire patient population in secure mental health services commissioned by NHS England and a projection of those held in the criminal justice system considered to have a profound mental health need.

37. Using a needs-led approach, develop a business case informed by current data to identify the population, and consider options available to best serve this population to reduce risk, assist throughput and provide best value for money.

38. Liaise with project lead for IMPACT (the provider led care collaborative for the East Midlands) to ensure plans are compatible.

Evidence demonstrating implementation of Recommendation 3

A paper proposing the third phase of the plan to expand the Forensic Community Mental Health Team.

39. This paper states: “the third phase of the plan to expand the Forensic Community Mental Health Team (FCMHT) was presented to the Mental Health, Leaning Disability and Autism System Delivery Board (MH, LD&A SDB) in August 2021. The Board gave their support and approval for the proposal in principle but requested that more work is undertaken around the modelling assumptions and funding streams. This document aims to provide assurance for the modelling and set out the stages for the funding to be released”.

40. At the meeting on 25/4/23, it was confirmed that support was provided. This is demonstrated in the ICB notes of the 26th October. A detailed description was given of the personnel in post and the development of the team.

Independent Enquiry action plan March 23 JE STEIS Ref: 2017/6089

41. This states: “The Operational Policy for Derbyshire Healthcare NHS Foundation Trust Forensic Team includes clarity over roles and responsibilities as well as communication between Derby City Council and Derby Healthcare NHS

Foundation Trust. A Joint Supervision Policy (Multi-Agency Management of High-Risk Individuals Guidance) is in place with both local authorities across Derby and Derbyshire, with an escalation process to raise any concerns".

42. At the meeting on the 25/4/23, the investigators were informed that Derbyshire Healthcare NHS Foundation Trust are fully involved as a member of IMPACT (responsible for the commissioning of low and medium secure mental health services and low and medium secure learning disability and autism services for adults). IMPACT attends the regular 37/41 meeting so there is good liaison.

Conclusion – Recommendation 3

43. The investigators have agreed that the requirements of the Recommendation 3 have been met and that processes are in place for ongoing monitoring.

For further Consideration:

44. The independent report suggested that, in liaison with third sector providers, options should be considered for the development of a high support hostel for patients who require on-going 24-hour support post discharge due to their clinical histories and risk profiles.

45. The recommendation for the high support hostel for the population of Derbyshire was taken to the Derbyshire Health and Housing Strategy Group (DHHSG), led by Public Health. The further work required on housing pathways has been added to the remit of the DHHSG to ensure that the accommodation pathway for people with Mental Health and Forensic needs is included in both city and county housing strategies.

Appendix 1 – Information provided by the Trust, March – May 2023

The following information to support evidence of progress against the action plan was provided by Derbyshire Healthcare NHS Foundation Trust:

1. Interagency working – multi-agency management of high risk individuals
2. Forensic Community Mental Health Team SOP
3. Reducing Reoffending and Offender Health Board agenda (example)
4. Reducing Reoffending and Offender Health Board notes
5. Derby and Derbyshire Reducing Reoffending Strategy
6. Reducing Reoffending and Offender Health Board risk matrix example
7. A paper proposing the third phase of the plan to expand the Forensic Mental Health Community Team
8. Service Specification
9. Forensic Supervision Policy Trust document
10. Clinical Educator job description
11. Practice Nurse Advocates
12. Living Well Structure
13. Living Well Operational Policy
14. Forensic Community Mental Health Team business case
15. The role of the social supervisor policy and procedure
16. Inter-agency collaboration re housing
17. JE action plan final for release word document without the above embedded.

Additional material submitted as evidence by the Trust on 22nd May 2023

18. Updated living well SOP which will be approved May 2023. Audit to be developed

19 Redacted FCMHT audit evidence

20 Update on how we maintain clinical contact via video, Derbyshire Healthcare NHSFT

21 Clinical Video Calls Policy and Procedure

22 Home Working Policy

23 Forensic Community Mental Health Team Clinical and Operational Policy, reviewed Spring 2023

24 Redacted MDT care plan

25 Patient Safety Team (PST) team actions on completion of action plan

26 Proposed new quality assurance group for incidents, complaints and low level intelligence

27 Workforce performance report

28 Forensic Team supervision extract

29 Trust supervision policy

30 Training report

31 Supervision audit report summary.