# Pathway Review: Black Country Healthcare NHS Foundation Trust

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## Pathway Review: Black Country Healthcare NHS Foundation Trust

# SUMMARY

1. A Pathway Review of care for people with severe mental ill health (SMI) who present a level of risk to others in Black Country Healthcare NHS Foundation (`the Trust') was designed to support learning and development following an incident that occurred in 2016. The work was commissioned by NHS England and led by our independent clinical team. The main report (attached) contains information about the methodology, the background, findings and agreed recommendations.
2. Information is provided about the range of very significant changes including the Trust merger, changes in national policy for community services, risk management, and care planning, and a range of local and national staff pressures, all of which affect the way that services are delivered now.

3. The report notes some new developments that are now being taken forward in the Trust which appear to be very good, including work to strengthen safeguarding, improve partnerships with the police, strengthen risk management, inpatient training, strengthen community mental health care, appoint new staff, and develop the `Health and Safety Hub'.

4. However, the report also notes some concerns relating to the way that multidisciplinary teamwork is arranged, and the way that formulations are articulated to make links between diagnosis, risk assessment/management and care planning in the inpatient units.

5. Acute inpatient care based on the delivery of MDTs nationally is one of the most challenging of all the mental health areas. The report notes that, in this Trust, action is already being taken. However, finding the most appropriate way to tackle the problem is not straightforward. The following two recommendations were made:

    a. A `Task and Finish' group involving clinical (medical, nursing, psychology) as well as management staff to consider how to improve the quality of MDT working in the context of the new policy framework being implemented by the Trust. It is for the Trust to decide how best deliver this and support the more senior staff to deliver their work at a day-to-day level, but it is likely that further training and/or continuing professional development will be needed; this work will ideally be completed within 6 months.

    b. Clinical and risk formulation to be strengthened so that treatment and care, risk and the management or mitigation of risk are articulated, not just for the staff working in direct care but also (as appropriate/possible) for patients, their families and carers. The aim is to reflect in formulations not only the way that staff communicate with each other, but also in the records of risk assessments, care plans, and plans. It should be possible to identify connections between these critical areas of work, the outcomes of care, and satisfaction with care as expressed by patients and their families.

## Pathway Review: Black Country Healthcare NHS Foundation Trust

# MAIN REPORT

## Introduction

1. This is the report of work to review progress in the development of a pathway of care for people in Black Country Healthcare NHS Foundation (`the Trust') presenting with severe mental ill health (SMI) who present a level of risk to others. It is designed to support learning and development. Its purpose is to provide assurance regarding the mental health care pathway taken locally for patients and families and identify any steps that should be taken to strengthen it following an incident in 2016. The following sections contain information about the methodology, the background, findings and recommendations that were agreed by the Trust at the end of the Review process.

## Background

2. In March 2023, NHS England and Improvement (NHSE) commissioned a review of local mental health services to understand the service changes made when a member of the public was killed. At the time of the incident, the perpetrator (the patient) had been under the care of the community treatment team, but he had seemed well. The patient who had been known to mental health services for six years, had had two admissions and been given a diagnosis of paranoid schizophrenia.

3. The Trust completed a `Root Cause Analysis Investigation' in 2016 and this concluded that the death could not have been predicted; however, it also identified several shortcomings in the way that care had been managed, including the way that information was collected about the patient's forensic history and the way that risk was communicated and managed.

4. Four recommendations were made concerning the management of risk, training on risk for staff, the Duty System, and management of the community-based depot clinics which were actioned by the Trust. However, as is normal when a mental health related death occurs, NHSE commissioned a further independent review. This took place approximately four years later, partly because the incident had been so serious and because time was needed to deliver the recommendations and understand the impact of changes in the service made to strengthen safety.

5. The independent NHSE Review commissioned (2020) took place, but there were delays associated with Covid 2020-2022. There were also challenges associated with operationalisation of the terms of reference, and differences between the Trust and the report authors regarding the way that the final report should be interpreted. As a result, the report of the Review was not accepted by the Trust, and it could not be taken forward.

6. A second Pathway Review was commissioned by NHSE in 2023 and a different independent provider was appointed[1]. Our team (see Appendix 1) is a small team with relevant clinical qualifications and experience of adult mental health services provision. Appendix 2 contains the terms of reference (TOR). The TOR were agreed between the Trust and representatives of NHSE and included a requirement to understand the current care pathway for someone with a SMI and a history of aggression; in other words, to ask: `*If a service user accessed services today with a similar history/problem, what would have changed/be different*?'

## Methodology

7. Authority for Pathway Reviews and investigations into mental health-related homicide is set out in NHS guidance by NHSE and is available on the NHSE website[2]. The primary purpose of Pathway Reviews is to understand and learn about the mental health system – in this case, to consider the needs of someone with an acute, psychotic, severe mental health problem, clearly in need of treatment, supported at home by his family.

8. Normally, when Pathway Reviews are undertaken, an opportunity is provided for the families of the perpetrator and of the victim to be involved. In this case the families did not want to participate, although NHSE provided information about the process. Our team therefore endeavoured to ensure that policies and practice around engagement with families were considered; more information about this is provided in the Findings section below. On the advice of the clinical team caring for the patient, a decision was also taken not to contact him. However, should he wish to see a copy of the report in due course, the clinical team will help ensure that this can be done.

9. In reviewing the development of present-day service provision, governance and quality systems, and the arrangements for identifying and escalating risks and opportunities for improving the quality of services, our team followed a conventional approach.

10. First, our team undertook a desktop review of documentary evidence[3] relating to, for example, risk policy, staffing, care planning, ward policies and governance arrangements. We read the Trust initial investigation and gathered policy documents to understand how services, such as the structure of community teams and outpatients' teams were provided in 2016, and how they are provided now. We had access to the first Pathway Review whose lengthy report (60 pages) and associated correspondence gave a perspective on the way in which risk assessment and management was being developed. We also obtained current, and more recent documentary evidence from 2023 and 2024 about risk, and we learnt about the development of new community mental health teams and other systems as part of the national policy to transform community mental health services. Information relating to this, and the detail of our findings, can be found in the `Findings' section below.

[1] Information about our team can be found in Appendix 1.
[2] https://www.england.nhs.uk/?s=homicide+investigations
[3] Appendix 3 contains a list of the documentary evidence reviewed.

11. Secondly, we spoke to a good number of staff, including[4] people at different levels of seniority with knowledge about adult mental health services. Information about the reasons for the Review and some of the background about the case was provided in writing. Some conversations were held by videoconference and others were held face-to-face during a two-day visit to Sandwell. In all cases, members of our team took care to ask open-ended questions that were designed to explore the complex issues associated with the identification of mental health needs and risks, the arrangements for treatment, and the steps to reduce risk and protect the patient and families, staff and members of the public.

12. Brief notes were drafted of the conversations that were arranged with staff, who were given the opportunity to correct the notes. However, staff were assured that their opinions would be held in confidence and detailed information about their roles and responsibilities have been removed to protect their identities.

13. Although none of the staff interviewed had been involved in the initial incident, they were nonetheless able to address key questions about the way in which services had been developed and changed since that time. In each case, staff were also offered the opportunity to make suggestions about which other staff it might be appropriate with whom we might speak. In this way, our team was able to pursue lines of questioning that we had not initially identified.

14. Members of the Trust were then given the opportunity to comment and correct any matters of fact contained in the final draft report of the Review and, where appropriate, they had opportunity to shape the wording of the advice given in the main report. The report will be copied to all those who participated and our team plans to supplement the final report with brief learning notes that can be used by the Board and the clinical teams, as required by the Trust.

15. We are very grateful to all the staff who took a very open and constructive approach to the collection of information for the Review, including the Trust Associate Director of Governance and Quality and the Head of Patient Safety who helped us to identify and gather essential information. Although the Review was focused on the NHS, it was also particularly helpful to have help and information from a Detective Constable who led a project for the West Midlands CID Major Crime Unit which has been so influential in the development of systems to improve safety working in partnership with the Trust.

16. Our team has no reason to suppose that the information that our team was able to gather based on the documentary evidence and the interviews is anything other than valid and reliable.

## Background and context

17. One very significant change since 2016, which is very important in relation to the way things currently work, concerns the national framework for provision of mental health

[4] See Appendix 4.

services (the Community Mental Health Transformation programme[5]). This sets out how new local funding is to be used to maintain and develop services through Integrated Care Systems (ICSs) to integrate primary and community mental health care. The transformation programme describes how community teams such as Early Intervention in Psychosis teams and other teams are now being provided, and how people with newer services such as those for people with personality disorder (PD) should be managed in future. More information about this is contained in the `Findings' section below.

18. A second, equally important contextual development concerns the merger (April 2020) between Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust. This has had a major impact upon the way that mental health services are provided not only in terms of teams and services, but also in terms of staffing. Some staff from the former Trust left, new staff were appointed, and new arrangements for training and managing them were (or are still being) developed. The Trust is also coping (like other parts of the NHS) with rising mental health demand, difficulties of recruitment and retention and a challenging financial climate.

19. In addition to these important points of context, mental health Trusts manage many risks when they deliver effective services for those people who, like this patient, presented many difficulties at the point he was acutely unwell and killed someone. The patient was male; in his early forties; he presented to services not only with a SMI (paranoid schizophrenia) but also a history of alcohol misuse, a history of domestic violence; he was unemployed, he had formerly been in prison, he lacked insight, and he was disinclined to take medication.

20. The patient was therefore not untypical of other people in contact with mental health services who are convicted of homicide. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[6] data show, for example, that stabbing is the most common cause of a death (46%), followed by a fight. Almost half of those convicted had a history of violence, many (53%) had been convicted of a prior violent offence and almost half had been in prison. Most had also been diagnosed with schizophrenia (85%), most were male, and had been unemployed. A third were non-compliant or non-adherent with treatment in the month before the incident and almost all had a history of alcohol and/or substance misuse.

21. Mental health-related homicides are nonetheless quite rare. Between 2010-2019 (the most recent period available) only 610 patients under the care of mental health services were convicted of a homicide offence, an average of 61 each year (a small reduction compared to the ten years before). This means that only 11% of homicides fall into this category, a figure that has remained broadly similar since 1992 when (NCISH) was established, although the average went down slightly during Covid for reasons that are unclear.

[5] https://www.england.nhs.uk/mental-health/adults/cmhs/

[6] National Confidential Inquiry into Suicide and Safety in mental health. Annual Report 2024. https://documents.manchester.ac.uk/display.aspx?DocID=71818

22. The facts reinforce the importance in mental health trusts of maintaining contact with patients with SMI to ensure a good quality of individual clinical risk assessment. Not only is individual assessment important, but treatment and effective management of risk is also essential, particularly if an individual's mental illness (and `Axis I' conditions[7] such as schizophrenia or substance misuse fall into this category) is associated with a lack of insight or a lack of awareness as part of their illness.

23. Three other important commonly associated areas associated with risk are also essential for mental health services to consider if risk is to be managed effectively. The first is broadly associated with *behaviour* rather than illness per se and concerns the importance of violence, aggression, domestic violence or other harms which carry a higher-than-average likelihood of recurrence, and which can co-occur with mental ill health.

24. The second concerns conditions (known as `Axis II') including neurodevelopmental disorders and PD which can also be controversial to diagnose and treat or manage. Such conditions are also commonly comorbid with mental ill health, they carry significant risks (harms to self and/or others), and although NHS guidance is clear, many services find themselves lacking knowledge, skills, or sufficient specialised staff.

25. The third potential concern relates to the way that services are organised. For example, it is not unusual in the NHS for significant elements of the assessment and treatment for certain conditions to be outsourced when people with SMI have mental illness; services for people with substance misuse are typically delivered this way. However, `outsourced' or `arm's length' services (charitable or 'third sector' services and statutory social, criminal, and educational services) typically have very different management hierarchies, their staff have different qualifications, and different levels of expertise. It can sometimes be difficult for them to plan, collaborate or share information with the NHS. Boundary disputes can obstruct or limit access to care. Together with its rarity, relevant knowledge about homicide amongst general mental health staff (unlike support for suicide risk) can sometimes be poorly developed, and when NHS systems are mainly focused upon health and treatment, these areas can sometimes receive too little attention.

26. It is beyond the scope of this Pathway Review to address all the areas which underpin all aspects of care and management of risk for people with SMI, especially those that have been outsourced or provided other than by the Trust. However, our team has endeavoured to address some of the main issues which the evidence suggests should be considered in this case, including the communication and arrangements to liaise with essential partners. We have also tried to address questions relating to the organisational context for the quality of care and the management of risk, including the way that the Trust now (as compared to 2016) can assure itself that staff, families and patients are safe.

[7] Diagnostic And Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) (multiple references) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4270276/

## Findings

27. In the following sections, the items in the TOR and recommendations arising from the initial investigation have been addressed below.

**TOR Item 1: Review the trust internal investigation, the recommendations and action plan and consider the care, treatment and services provided at the time. Review the embedding of the recommendations and any changes to services made.**

28. Our team reviewed the initial investigation commissioned by the Trust which was led by two senior members of the clinical staff unrelated to the initial incident. Although it was agreed with NHSE and the Trust that it was inappropriate to re-visit the clinical records of the incident in 2016, and nor were there any staff available who had been present at the time with whom we could speak, we have no reason to believe that the investigation was not managed effectively. The report is focused appropriately, the arguments were evidenced, and the recommendations and Action Plan appeared to be sound. The recommendations have been reviewed by our team and, together with the corresponding TOR items to which they closely relate, they have been addressed in more detail in the following sections. Our team therefore believes that satisfactory progress on the first TOR item has been implemented.

**TOR Item 2: Involve the families of both the victim and the service user as fully as is considered appropriate, and if they have any questions attempt to answer them.**

29. Neither the patient's family nor the family of the victim wanted to have any involvement in the Review (or in the investigations). However, our team was able to ask a range of questions in relation to policy, and the staff and organisational arrangements being made to ensure that families and carers are currently involved effectively in the Trust's mental health care. Initially, we discussed care with a member of staff working to support Safeguarding. This team works across four local areas (Sandwell, Walsall, Wolverhampton and Dudley) in four Divisions (Children, Young People and Families, Learning Disabilities and Adult Mental Health) all of which have been developed since 2020 when the merger took place. We were also able to review a range of relevant documentary evidence (see Appendix 3).

30. The Safeguarding Team is relatively new, and work is still in progress. For example, new roles (a named safeguarding Doctor and three Lead Nurses for adults) have been established although they are not yet fully embedded. An Advice Line has already been established to support staff who may be unclear about whether to make a referral, and appropriate training has been implemented. The team also appears to be well

linked across all four MASH[8] and MARAC[9] meetings and work has been started to strengthen the way that the Trust considers `Think Family'[10], the approach that concerns the steps that need to be taken to ensure that issues relating to the families' needs can be addressed so that support, if necessary, can be provided. A Task and Finish Group has been established to consider this in more detail by the Trust.

31. Although the safeguarding team has not, at this point, been very well connected with the Police, the team is also currently considering how to link safeguarding arrangements with MAPPA[11] and with forensic services. Even though the team would prefer to have more staff in this area, our team considers that, owing to the fact that they are still in their infancy post-merger, safeguarding arrangements look to be in a good state of preparedness to move forward.

32. Our team was also able to speak with the Patient Experience and Involvement (PEI) manager for the trust. The PEI manager is responsible for service user involvement and engagement, with the aim to support people at an early stage before complaints are made; co-produce services where possible and involve all those with an interest in the service.

33. The team works with approximately 40 Lived Experience Consultants (LECs) checked, where necessary, using the Disclosure and Barring Service (DBS), who help to ensure that there is a good level of engagement with patients and families. As a relatively new service, like the arrangements to manage safeguarding, patient experience and engagement systems are relatively young. However, our team was impressed with the sophisticated level of thinking about how to manage this challenging area. The team is also thinking about the way in which the `Triangle of Care'[12] is managed for carers. The Trust is set to achieve its first star accreditation for Crisis and Inpatient services in October 2024 with a second star set to be achieved in later 2025.

34. There is still some way to go to embed these new approaches at the clinical level and embed a more holistic approach to families and carers in planning and delivering ongoing care. However, our team considers that a range of impressive steps have been taken to strengthen the way that the Trust engages with patients, families and carers and important steps have been taken to strengthen safeguarding.

[8] The Multi-Agency Safeguarding Hub (MASH) is a single point of contact for all safeguarding concerns regarding children and young people. It brings together expert professionals from different services that have contact to make the best possible use of their combined knowledge to keep people safe from harm.
[9] The Multi-Agency Risk Assessment Conference (MARAC) is a meeting where agencies talk about the risk of future harm to people experiencing domestic abuse and their children and draw up an action plan to help manage risk.
[10] Think Family' is an initiative introduced by the Department for Children, Schools and Families (DCSF) in 2008 following the Cabinet Office 'Families at Risk' Review. Since then, the approach has been expanded and developed, particularly in mental health.
[11] Multi-Agency Public Protection Arrangements ensure that various agencies such as Police, Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community. MAPPA are established by Sections 325 to 327 of the Criminal Justice Act 2003.
[12] The Triangle of Care concerns a therapeutic alliance between carers, service users and health professionals which aims to promote safety and recovery and to sustain mental wellbeing by including and supporting carers.

**TOR Item 3: Identify the issues arising from this case and carry out a review of the current pathway with reference to these issues. TOR items 4, 5 and 6 (present day services, compliance with policies and statutes, and good practice) are addressed in the body of the text below.**

35. As a starting point, we began with the recommendations which were identified in 2016:

    a. Risk assessment and tools for violence and aggression.
    b. Training for staff on the formulation of risk rather than completion of risk tools.
    c. The Duty System, documentation, and involvement of medical staff.
    d. Review of `stable' patients and how they are managed.

36. The first two recommendations above (a. and b. above) have been addressed below. The third recommendation (c) concerning the Duty System and staffing is also considered below. The fourth recommendation concerning the way that patients are managed when the acute phase of their illness is over has been addressed in the section called `Ongoing care' and this is where our team has addressed issues relating to the way that care planning is delivered.

**Risk Assessment and Management (acute).**

37. Since the time of the incident in 2016, the Trust has changed the way that clinical risk assessments are undertaken. Now, in adult mental health (and this applies to inpatient as well as community services), the Trust uses an approach to risk assessment which was designed with support from Steve Morgan[13]. This is an evidenced-based initial risk assessment screening tool designed to develop an initial risk management plan, and from which further areas that may require more in-depth risk assessment can be developed, depending on the age and needs of the patient.

38. The tool is reasonably well established in clinical practice, it includes guidance and questions about what are called `static' factors (historical evidence relating to, for example, harms or child abuse) as well as `dynamic' factors which can change over time, such as alcohol, mental state, attitudes, or social factors. As such, it aims to deliver risk assessment in accordance with national NHS guidance and guidance published by the Royal College of Psychiatrists (RCPsych) (2007). It also meets more recent advice (NHS Guidance for March 2022) which says:

    '*It is therefore important that assessment of risk forms part of a wider assessment, and that safety planning is built into the wider care planning process rather than being divorced from it.*'

39. The Trust's current policy on risk assessment appears cogent and is clearly written. It is also very clear in aiming for information to link formal assessments of mental illness (diagnosis) with a formulation (influenced by social and other factors), a risk assessment, and a clear Care Plan. But although several members of the Trust senior

[13] Steve Morgan (2001) `Clinical Risk Management: A clinical Tool and Practitioner Manual' The Sainsbury Centre. ISBN 1870480449

team support the use of the Steve Morgan tool, our team could see that some senior staff and some front-line staff are much less positive about it.

40. Although it is true that there will always be variation in staff preferences, our team did not consider that the Steve Morgan tool should necessarily be abandoned for the future. Rather, we considered that the problem lay less with the risk tool than with its interconnectedness across care planning and communication. This relates to the way that inpatient care is organised to ensure that risks and care planning are linked together (and this was highlighted as an issue and a recommendation when the initial investigation took place).

41. Since the time of the merger, the Trust has been leading an inpatient transformation training workstream that has already been identified for risk formulation. Risk assessment, risk formulation and risk management/mitigation training are currently being developed internally by nursing and psychology leads. This work will cover both inpatient and community services. It is planned for this to be rolled out in a 'train the trainer' approach towards the end 2024.

42. However, when our team was able to see the random sample of current inpatient mental health case notes that the Trust was kind enough to let our team see, we could not see sufficient evidence in patients' care records (although diagnoses were recorded) that attention had been paid to linking formulation, treatment and care, risk and risk mitigation together. We also noted that staff appear to be aware of the problem, even though opinion appears to be divided as to the reason.

43. Some thought that the problem was simply a reflection of the way that the Trust is organising RiO[14]. RiO is still in its infancy in this Trust, and, like many other mental health Trusts, staff are not using (nor are they required to) fill in the formulation section. In fact, many other Trusts do not use this tab, preferring to emphasise care plans instead. For example, in another Trust (details can be supplied if permission is given) RiO has been adapted so that it is not physically possible to open a case note without checking the risk assessment first. Although some of the staff are sometimes frustrated by the extra time it takes to make an entry, it does seem to help ensure that risk assessments are always seen, and it means that a care plan cannot be completed without a risk assessment being included.

44. Our team was therefore pleased to see that the Trust Clinical Systems Transformation Lead has identified opportunities to alter the digital form view of the tool to improve the way that the risk management plan section is used in practice. We note that audits of record keeping for inpatient, CRHTs and CMHTs are now in place and information is reported monthly through the Quality and Safety team. These audits will be reviewed as part of ongoing work to transform inpatient, community and digital systems. The Clinical Systems Transformation Lead will work with the clinical leads to ensure that the documentation of risk and care planning on RIO is supported.

[14] RiO is an NHS Electronic (i.e., paperless) Patient Record (EPR) system in widespread use within mental health services designed to support the delivery of care.

45. What matters is that risk, care and effective management are linked clearly in several ways, not just in RiO but also in Care Plans and other arrangements. Our team noted that a new Inpatient Operational Policy developed earlier this year in March (to be ratified in May) now also sets out clear standards of practice to support patients through their admission to hospital, any transitions, and subsequent discharge from hospital. This makes it clear that a MDT formulation review should take place within 72 hours of admission, and care plans, safety plans, risk assessments should now be updated following each MDT ward review. An MDT escalation process has been developed for both inpatient and community services which aims to strengthen the senior MDT oversight and review of high-risk patients.

46. However, until the new policies can be embedded, our team thought that some further work is needed to engage and support or teach the staff at a day-to-day level. This is evidenced by not only the views of the staff with whom we spoke, but also the Care Plans which, we could see, were limited. It was suggested to us that the senior staff (e.g., senior medical, nursing and psychology staff) don't always seem to have sufficient time to share information with their teams to formulate each case, link risk and care together. Insufficient time (they argued) is available to support the staff in the MDTs which is where risk, care, formulation, and future planning would normally be brought together. They thought that staff were typically `firefighting' in the context of pressure on beds, demands from patients, staff shortages, increasing use of Bank/Agency staff, and limited financial resources and they did not have enough time in each MDT to think in sufficient depth about each patient. This may be due to the very large number of MDTs each week, coupled with a high number of patients being admitted from outside the locality (post-merger) whom they do not know.

47. The MDT remains the heart of care in most mental health services and although all the medical staff appear to be very stretched in this Trust, the more junior staff do seem to need more help to formulate individual cases at a day-to-day level to ensure that risk, care plans, treatment, and information for the patient are linked effectively. This appears particularly clear for those cases which are more complex.

48. Our team thought that there could be value in specific staffing to manage oversight of the most complex cases who may present such a challenging mixture of personal histories, complex mental ill health, and substance misuse, especially if they do not reach the threshold for referral to forensic psychiatry. In one other Trust, for example, and because they recognised this problem as being widespread, a new Enhanced Risk Assessment (ERA) Team has been established. This consists of three facilitators (Assistant Psychologists), input to the Community Forensic team and the Low Secure Unit. The aim is to improve links between general and forensic services via training, provision of resources, communications, signposting, liaison with MAPPA, and support the inpatient teams. The team is managed by the Executive Director of Quality and Medical Leadership and the lead for adult mental health and forensic psychology.

49. Our team was nonetheless pleased to learn positive feedback about the links between general adult mental health and specialised forensic services in the Trust. New roles are already being established in the form of a substance misuse lead and a lead from

Assertive Outreach who will engage and support patients proactively. Furthermore, a Community Enablement and Recovery Team (CERT) team will, in future, offer intervention and intensive support for the most complex patients (based on need rather diagnosis) to reduce the requirement for residential rehabilitation placements and/or reintegration following a period of residential rehabilitation placements. Our team thought that would likely help.

**Ongoing care.**

50. The third and fourth recommendations in the initial investigation (*The Duty System, documentation, and involvement of medical staff* and `*Review of `stable' patients and how they are managed'*) concern several important areas of care that are linked. First, care planning and the way that outpatient care is provided by the Trust is now affected by new guidance.

51. The National Institute for Health and Care Excellence (NICE)[15] published Quality Standard (6) updated in 2019 concerning the way that people using mental health services should now agree a care plan with health and social care professionals. It sets out how each patient should have a statement setting out the needs of the person using the service, activities that promote social inclusion, and a plan containing what to do in the event of a crisis[16]. Five foci are identified to ensure that care is meaningful and intervention-based; including the need to have a named key worker, care that is co-produced with the patient, support for carers, and care that is accessible and responsive. Importantly, the new system does not have to conform to the Care Planning Approach (CPA): the system of care planning that was being used in 2016 when the incident occurred.

52. Although steps are now being taken within the Trust (aligned to the Community Transformation and work streams for 24/25 led by the Adult MH Division Head of Nursing) to review how and whether to replace CPA, the Trust has not yet taken action. Some senior staff reported to our team that the reason for this lies in work to amalgamate the Trusts in 2020, together with delays caused by Covid. Our team has no view on the wisdom of continuing to use CPA rather than one of the other systems now in widespread use (such as DIALOG +)[17] because, whilst we believe it is essential for staff to find ways to operationalise the principles outlined in the NHS guidance, there is probably no single perfect solution or tool to deliver care planning that suits everyone. However, we urge the Trust to consider, with the clinical and medical staff who need to use it, the way that care planning, risk, and formulation could be strengthened. The sections on clinical risk assessment and management above refer.

53. A second very significant change has also been made since 2016 in relation to the provision of ongoing care for patients who are stable and being managed in the

[15] https://www.nice.org.uk/guidance/qs14/chapter/quality-statement-6-joint-care-planning
[16] https://www.england.nhs.uk/publication/care-programme-approach-position-statement
[17] DIALOG + is an evidence-based user-led process designed to record patient-reported experience (PREMS) and patient-reported outcome measures (PROMS) which directly assess the lived experience of service users. The aim is to capture perspectives on a person's health status and essential subjective constructs such as health, quality of life, goals, and social inclusion.

community is the Community Mental Health Transformation programme[18] aimed at developing new and integrated models of primary and community mental health care. In principle, Integrated Care Systems (ICSs), and new Primary Care Networks (PCNs), mean stronger care in the community. New local funding will be used to maintain and develop new services for people who have specific or additional needs, including Early Intervention in Psychosis (EIP), complex mental health difficulties associated with a diagnosis of 'personality disorder' (particularly patients with EUPD[19] who challenge more traditional ways of NHS working), mental health rehabilitation, adult eating disorders and neurodevelopmental disorders.

54. Although it's still early days, the Trust is developing a new way of working and modernising community mental health services for adults in Dudley, Sandwell, Walsall and Wolverhampton. Across the Trust as a whole, mental health services are still delivered using community mental health teams (CMHTs) but these are now aligned with Primary Care Networks (PCNs) and a new system of outpatient departments, specialised teams and staff. PCNs enable a greater degree of more integrated health and social care and the addition of new Mental Health Practitioner roles (ARRS) also provides support using professionals with different backgrounds to deliver team working. Staff reported to our team that this appears to be working well.

55. It also appears to be a strength that consultant psychiatrists cover both inpatient and community services, which means that the service user pathway, knowledge and communication are not impeded. However, when our team visited, all the staff to whom we spoke acknowledged the challenge of managing staff[20] who are in very short supply. The wards and community services are extremely busy, and recruitment is difficult amongst doctors (particularly consultant psychiatrists) and psychologists. Bank and Agency staff levels (perhaps up to 50%) can also be very high, as is the case across mental services nationally. It is therefore helpful to note that the Trust has a strategy for recruitment and retention and a significant level of work has been achieved in this area, particularly in relation to the merger when some staff of the former Trust left or retired. However, given that it is especially difficult to manage the very large number of MDTs that the nurses currently support, our team nonetheless believed that the organisation of multidisciplinary teams in the inpatient service could be improved further. Further information about this is provided below.

### Assuring quality

56. Our team was able to consider the policies and organisational arrangements to assure patients, carers and families are safe, and that risk and serious incidents are responded to, and that where they do occur, they lead to learning and change. For

[18] https://www.england.nhs.uk/mental-health/adults/cmhs/

[19] EUPD is Emotionally Unstable Personality Disorder. https://www.nice.org.uk/guidance/cg78

[20] Mental health care has, on average, a much higher turnover of staff than the rest of the NHS. For example, 13.6% of all mental health staff left in 2015/16, compared with 8.6% in acute NHS trusts. The King's Fund report 2024, 'shows that the workforce has grown, but the rate of increase varies greatly by staff group: nurses grew by 3%, whereas the number of therapists and support staff grew more (45%). Mental health inpatient services have also suffered more, with certain medical and psychiatric specialities, such as old-age psychiatry and learning disabilities, where medical staff are unable to fill all the placements they need.

example, our team was able to see that the Patient Engagement team has clear links with the formal complaints system and take responsibility for reports to the Trust Board via the several quality and safety groups, Patient Safety, and the Divisional Quality Improvement Groups (QIGs). We could also see that the Patient Engagement team participates in the CQC Patient Survey (NPSP), and governance arrangements to link this work into the Trust Board appear to be robust. Similar clear arrangements exist in relation to links between Safeguarding and Compliance and Safety. Our team was also able to access information relating to the way that the Trust Board manages the range of information about risk, and this appears to be of a good quality.

57. Our team was also able to highlight two positive developments within the Trust since the merger. The first, concerns development of the `Health and Safety Hub' which has an access point in each Division (learning disabilities, older adults, adult mental health, etc) containing information about risk. Information is provided about, for example, ligature risk, lone working, key learning points from reviews or investigations and other information designed to support and educate staff in relation to the management of risk and their own safety, including in relation to suicide. Information is also provided in `Easy Read' for people with a learning disability or formulated to make it relevant for families and children, and information is provided, for example, on how to get help in a crisis.

58. The second positive development (and the Health and Safety Hub is linked to this) concerns development of an effective partnership between the Trust and the Police designed to improve partnership working and remove the barriers to reporting criminal behaviour. The programme (`Operation Stonethwaite'[21]) was initiated two years ago and is led by a Detective Constable with experience in public protection, domestic violence and safeguarding for people with mental health problems. It was initially focused on repeat offenders and when the programme was developed in this Trust, there was a less than two per cent rate of conviction following assaults; now, the rate is closer to 30 per cent. This has been achieved through provision of guidance, teaching, training, and support for staff to ensure that they are better informed about their rights and what the police can or should expect. Together with the policy of `Right Care, Right Person[22], the programme is now making a significant difference to improve the safety of staff and patients.

59. Our team spoke to one of the local security managers appointed at the Trust who helps to manage this. Although, as might be expected, much of the work is focused on physical security (CCTV, intruder alarms, access and egress) his work also concerns the management of violence and aggression. Staff are now being provided with

[21] https://hmicfrs.justiceinspectorates.gov.uk/publications/joint-thematic-inspection-criminal-justice-mental-health-needs/ or https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhmicfrs.justiceinspectorates.gov.uk%2Fpublications%2Fjoint-thematic-inspection-criminal-justice-mental-health-needs%2F&data=05%7C02%7Cengland.annerichardsonconsulting%40nhs.net%7Cf21fccd0b2d74e108e2b08dc58801d19%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638482554671123623%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=P6i9H1liu0ooAkMsjn2t8JcCBEFOLq06%2BO5BZBx0n%2FA%3D&reserved=0

[22] Right Care Right Person policy. https://www.met.police.uk/notices/met/introduction-right-care-right-person-model/

information about what criminal behaviour means. All incidents are examined, and if the patient lacks capacity (for example, is very unwell), staff will not call police. However, if a patient with capacity assaults someone, and if the victim is willing, the patient can be prosecuted. This, together with better information across the whole mental health system for everyone, has been very important in the development of a very different culture around violence, including within the inpatient MDTs where Police may now be involved as needed. There are now opportunities to consider all the issues, understand what is possible and appropriate, and partnerships within MARAC and the MASH have improved. Our team considers that the work in these areas is of an excellent quality.

## Conclusions

60. Our team is very grateful for the open and constructive approach taken by members of the Trust team to the Pathway Review for people with SMI who present a level of risk to others. Whilst it is beyond our scope to address all the areas which underpin all aspects of care and management of risk for people with SMI, especially those that have been outsourced or provided other than by the Trust, our team has endeavoured to address the main issues which the evidence suggests should be considered in this case, including the communication and arrangements to liaise with essential partners.

61. Our team has also endeavoured (TOR Item 7) to fulfil the requirement to provide a written report to NHSE that includes agreed, measurable and sustainable recommendations (see below).

62. We noted some exceptionally strong, new developments that have been, or are being taken forward. For example, we wanted to commend the Trust for its work on the `Health and Safety Hub' and the work that has been undertaken in partnership with the police. However, we also had some concerns; these relate to (a) the way that the multidisciplinary teams in the inpatient units are arranged and (b) the way the Trust is trying to make effective links between formulation, diagnosis, risk assessment/management and care planning.

63. Delivery of acute inpatient care based on the delivery of MDTs nationally is one of the most challenging of all the mental health areas. Staff changes, staff shortages, growth in demand from new areas (such as personality disorder or neurodevelopmental disorders) as well as the financial climate combine to make working lives very challenging. However, in this Trust, there is an almost overwhelmingly large number of inpatient MDTs led by senior staff who `reach in' to the inpatient service from elsewhere in the community – more MDTs per week than our team has seen recently. Although the inpatient team members with whom we spoke were impressive and they spoke with passion and commitment about their work, they are under tremendous pressure. Although this matter is addressed in the Inpatient Operational Policy and is a matter that is being addressed in relation to the management of inpatients from outside the area, our team would encourage the Trust to address this.

64. Finding the most appropriate way to tackle the problem is not straightforward. Ideally, action is already being taken to strengthen the quality of inpatient MDT working and improve planning, recording, and engagement with patients and their families so that opportunities for treatment and management are clear. However, at this point, our team could not be clear that the problem is resolved.

65. Secondly, work is needed to strengthen links for individual patients between case formulation, diagnosis, risk assessment/management and care planning. This is because it was not always very easy to find a formulation in the notes or see how it connected to treatment.

66. In both these areas, it is unlikely that a solution can be found by simply strengthening RiO (the electronic records system due to be developed further) which has been introduced relatively recently. Nor is it likely to be sufficient to reform the risk assessment/management approach (also due to be reviewed), strengthen staff training, or change the care planning system. All these areas are likely to improve over time. Important steps within the Trust are being taken in relation to the transformation of services which our team believes are likely to deliver results. However, we urge the Trust to develop a local, bespoke, participative and multi-disciplinary approach based on engagement with those who are most affected – that is, the clinical teams themselves.

67. The following recommendations (TOR Item 8) which have been agreed with the Trust have been articulated to help the Trust to develop measurable and sustainable recommendations. However, at the time of writing and Action Plan which operationalises the recommendations has not been completed; this will be submitted to NHSE by the Trust in due course.

68. TOR Item 8 which concerns material for the Trust relating to the learning in this report, and its recommendations, has also been considered. As a first step, the Executive Summary has been circulated to all those staff who were involved in the case, and/or those involved in the development of the recommendations. The full report has also been shared with the Trust Board and discussed.

**Recommendation 1 MDT working**

69. **MDT inpatient working** is one of the most challenging areas of mental health care. We recommend that the Trust establishes a `Task and Finish' group involving clinical (medical, nursing, psychology) as well as management staff to consider how to improve the quality of MDT working in the context of the new policy framework being implemented by the Trust. It is for the Trust to decide how best deliver this and support the more senior staff to deliver their work at a day-to-day level, but it is likely that further training and/or continuing professional development will be needed. We recommend that the Trust completes this work within six months.

### Recommendation 2 Clinical and risk formulation

70. **Clinical and risk formulation** should be strengthened so that treatment and care, risk and the management or mitigation of risk are articulated, not just for the staff working in direct care but also (as appropriate/possible) for patients, their families and carers. The aim is to reflect in formulations not only in the way that staff communicate with each other, but also the records of risk assessments, care plans, and plans. It should be possible to identify connections between these critical areas, the outcomes of care, and satisfaction with care as expressed by patients and their families.

# Appendix 1

### Terms of Reference for a Pathway Review into a historic case (2016/17208)

**Purpose of the Investigation**

A Pathway review is aimed at examining the present-day situation. It aims to consider the service provision at the time of the offence and examine the learning/improvements that have subsequently taken place. It will ask the fundamental question of:

"If a service user accessed services today with a similar history/problem – what would be different?"

1. Review the trust internal investigation, the recommendations and action plan and consider the care, treatment and services provided at the time. Review the embedding of the recommendations and any changes to services made.

2. Involve the families of both the victim and the service user as fully as is considered appropriate, and if they have any questions attempt to answer them.

3. Identify the issues arising from this case and carry out a review of the current pathway with reference to these issues.

4. Review the development of the present-day service provision governance and quality systems, arrangements for identifying and escalating risks and opportunities for improving the quality of services.

5. Review and assess compliance with local policies, national guidance and statutory obligations.

6. The review process should also identify areas of good practice, opportunities for learning and areas where improvements to services may be required.

7. Provide a written report to NHS England that includes agreed, measurable and sustainable recommendations.

8. Produce a learning document, suitable for sharing with other providers, on the learning from the investigation

## Appendix 2

### The Investigation Team

Anne Richardson, Director of ARC, is a clinical psychologist by training who specialised in work with adults with severe mental ill health and long-term needs. Anne is an experienced teacher/trainer and communicator having worked as joint Course Director of the D Clin Psy at UCL and as Regional Tutor at UEL in London; she also has experience in relation to the development and delivery of NHS policy as Head of Mental Health policy at the Department of Health. Anne was instrumental in the development of the National Service Framework for Mental Health and, with Sir Jonathan Michael, for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Anne chaired the Expert Reference Group (2016/17) for an investigation into deaths in Southern Health and has worked since 2010 as one of NHS England's providers of independent investigations into serious incidents, including mental health related homicides, and Domestic Homicide Reviews.

Dr Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for inpatient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health, he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework. He worked until recently as a non-Exec in the north of England.

Adrian Childs started his career in Surrey in the mid-1980s, training as both a general and mental health nurse. He has been a director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust and as Director of Nursing at Leicestershire Partnership Trust. Adrian earned a distinction in his MSc at the University of East London in the mid-1990s; he also holds a diploma in leadership, mentoring and executive coaching. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. In 2014 he was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester. His previous experience includes serving as Deputy Chief Executive and Director of Nursing at Devon Partnership NHS Trust and Newcastle, Northumberland and North Tyneside Mental Health Trust. Most recently, Adrian he worked as interim Director of Nursing at Avon and Wilts NHS MH FT.

# Appendix 3

**Documents reviewed.**

Comprehensive (Level 2) Root Cause Analysis Investigation Report (2016).

Report and background papers for the initial Pathway Review 2023 commissioned by NHSE.

Criminal Justice Inspection, Care Quality Commission and Healthcare Inspectorate Wales (2021) `A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders.'

Clinical Risk Management Policy (revised September 2022 after the merger) including information about, for example, lone working, health records, violence and aggression, physical health, incidents, and complaints, care planning and clinical risk, CQC requirements, national standards, and staff training).

Sample of Trust Board Packs from 2022, including public information sheets, Board profiles, agenda and papers.

Care Planning and annexes (the Single Assessment Process (SAP), the CPA Common Assessment Tool)

Clinical Risk Tool (Sainsbury tool used formerly, and Steve Morgan tool used currently).

Clinical Audit Policy.

Black Country Healthcare NHS Foundation Trust Quality and Safety Committee papers (2022 – various).

Board papers (various).

RiO policy.

Organisational arrangements: `Adult Mental Health Triumvirate' June 2023

Governance Structure August 2023.

IOPC (March 2024) `Learning the Lessons: mental health'. Supporting Compassionate Care for Vulnerable People.'

Performance Review Group (PRG) Terms of Reference (July 2023).

## Appendix 4

## Consultees

(Names and titles redacted)

Representatives were included from Psychiatry, Nursing, Safeguarding, Patient Experience and involvement, Health, Safety and Security, Patient Safety, Trust Management, and Governance and Quality.