Independent Quality Assurance Review

Humber Teaching NHS Foundation Trust
NHS Hull Clinical Commissioning Group

Service User Ms C

Final Report

July 2022

Niche Health and Social Care Consulting
4th Floor, Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

July 2022

Dear Karen,

Independent Quality Assurance Review, Humber Teaching NHS Foundation Trust and NHS Hull Clinical Commissioning Group

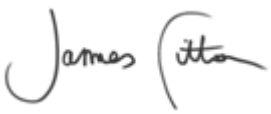
Please find attached our Final Report of 18 July 2022 in relation to an independent quality assurance review of the implementation of recommendations resulting from the independent investigation into the care and treatment of a mental health service user, Ms C, that was published in July 2021.

This report is a limited scope review and has been written for the purposes as set out in the terms of reference for the independent investigation alone and is not to be relied upon for any other purpose. The scope of our work has been confined to the provision of an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF). Events which may occur outside of the timescale of this review will render our report out of date.

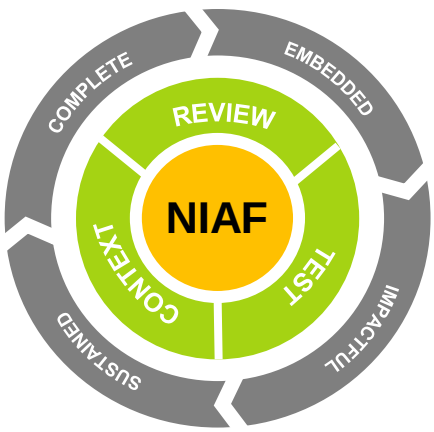
Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This report is for the attention of the project sponsor and stakeholders. No other party may place any reliance whatsoever on this report as it has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final signed version of this report should be regarded as definitive.

Yours sincerely,



James Fitton
Niche Health and Social Care Consulting Ltd



Niche Investigation Assurance

insight integrity impact

Contents

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Senior Consultant
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1. Method

1.1 Background and context for this review

NHS England and NHS Improvement commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF). This is intended to provide an assessment of the implementation of the actions developed in response to recommendations from the Niche independent investigation into the care and treatment of a mental health service user, Ms C, that was published in July 2021.

1.2 Review method

This is a high-level report on progress to NHS England and NHS Improvement, undertaken through desktop review only, without site visits or interviews. The assurance review focuses on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

Our work comprised a review of documents provided by Humber Teaching NHS Foundation Trust (the 'Trust'). These included policies, procedures, audits, meeting minutes, training presentations and staff communications.

We have not reviewed any health care records because there was no requirement to re-investigate this case in the review's terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

1.3 Implementation of recommendations

The Niche independent investigation made six recommendations to the Trust; these are listed opposite.

1	The Trust should align the **'**Care Programme Approach (CPA) and Non-CPA Policy and Procedural Guidance' and the 'Operational Guidance, Hull Adult Community Mental Health Teams' so that staff are clear about the factors that must be taken into account when discharge from services has been requested or is being considered, and the operational protocols to be followed when discharge has been agreed, especially for those service users with a history of violence.
2	The Trust must assure itself that risk assessments and CPA documentation are kept up to date, and are of the appropriate quality, in line with Trust policies.
3	The Trust should consider, and reference in appropriate policies, the need for additional methods of monitoring compliance with Lithium to mitigate the risks of non-concordance with treatment plans for patients with a history of non-compliance and who are at risk of relapse.
4	The Trust must update the 'Operational Guidance, Hull Adult Community Mental Health Teams', to clarify the role of the Consultant Psychiatrist within the CMHT, and when a medical review of a service user's care should be sought. The Trust must assure itself that this revised guidance is being followed.
5	The Trust should seek to agree with the police how and when it can engage with families who have been affected by a mental health homicide.
6	The Trust should evaluate the evidence underpinning its action plan within three months to ensure it can demonstrate to the CCG that each action has been completed, tested and embedded. In instances where actions cannot be evidenced as closed, steps should be taken to fulfil the original commitments of the action plan within six months.

2. Assurance summary

Scoring criteria key

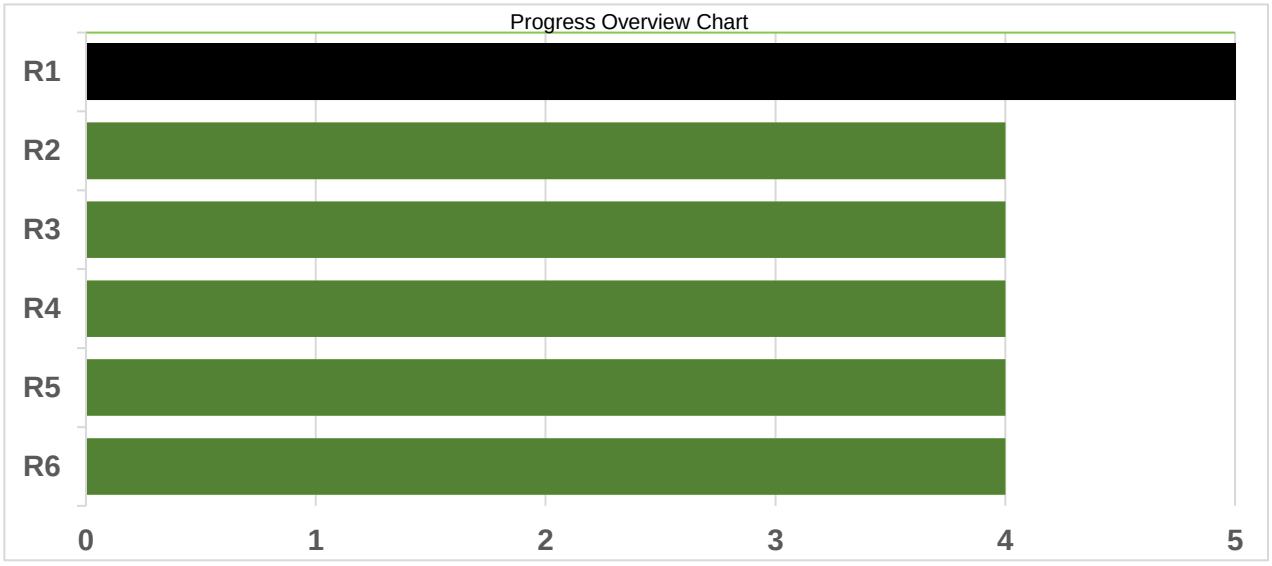
We use a numerical grading system to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained.

3 is regarded as a good score as it reflects action completion. Scores of 4 and 5 are harder to achieve within the timeframe from publication of the investigation report to now, with the latter rating being assigned on more limited occasions primarily due to the cycle of testing that is required to demonstrate sustained improvements being achieved.

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

Implementation of recommendations

We have rated the progress of the actions which were agreed from the recommendations made. Our findings are summarised below:



Summary

The Trust has prioritised improvements across all areas of learning following the independent investigation and progress has been made across all recommendations.

Where appropriate, we have provided examples of further assurance which is required to demonstrate actions are embedded and/or sustained as appropriate. Some headline commentary to support these ratings has been provided in the following pages. Appendix 1 (evidence review) provides a more detailed assessment against each piece of evidence which has been submitted to Niche.

2. Assurance summary (cont.)

Recommendation 1

The Trust should align the **'**Care Programme Approach (CPA) and Non-CPA Policy and Procedural Guidance' and the 'Operational Guidance, Hull Adult Community Mental Health Teams' so that staff are clear about the factors that must be taken into account when discharge from services has been requested or is being considered, and the operational protocols to be followed when discharge has been agreed, especially for those service users with a history of violence.

Niche assurance rating for this recommendation **5**

Key findings: The Trust provided 22 documents to evidence the progress made in relation to this recommendation. This included an updated CPA Policy which now requires staff to consider historic violence or aggression prior to discharge with onward communications to the GP and other agencies as required. The operational guidance for the Community Mental Health Team (CMHT), has been aligned to this with inclusion of relevant sections of the CPA Policy.

The Trust had communicated the changes clearly to all staff, using a range of methods to update people on the specific changes in policy. Also, that these changes had been implemented following the learning from a serious incident. We reviewed evidence of discussion in committees, sharing via Trust-wide emails and messaging on the Trust intranet which is accessible to all staff.

Practice had been tested through monthly audits across all CMHTs in the Trust between June to December 2021. The audit asked five questions, with questions specific to the assessment of historic violence and aggression and to sharing this information with the GP. Audits demonstrated 100% compliance with the standards in the CPA Policy, with only one record exception (July 2021) which was found to be a recording issue and not a failure to complete the assessment or share information.

Residual recommendations:

N/A

Recommendation 2

The Trust must assure itself that risk assessments and CPA documentation are kept up to date, and are of the appropriate quality, in line with Trust policies.

Niche assurance rating for this recommendation **4**

Key findings: The Trust had implemented new tools and processes to support the monitoring of compliance with required standards at clinician and managerial level. This includes the use of a clinician dashboard, a new process to add diary reminders for all clinicians prompting them to complete reviews and audits; audits are then reviewed at divisional clinical governance meetings.

High rates of compliance with the required standards for risk assessments, care plans and CPA documentation were evidenced in the audit results provided although there was some variation in compliance in some cases. Audits covered periods from January 2021 through to January 2022. We could also see that discussion of the results and improvement actions had taken place in governance meetings, chaired by matrons during 2021. This included evidence of response plans when compliance fell below the expected levels and increased monitoring until this had been resolved by the team.

Residual recommendations

Complete the cycle of audits and improvement actions until changes made are embedded in practice.

2. Assurance summary (cont.)

Recommendation 3

The Trust should consider, and reference in appropriate policies, the need for additional methods of monitoring compliance with Lithium to mitigate the risks of non-concordance with treatment plans for patients with a history of noncompliance and who are at risk of relapse.

Niche assurance rating for this recommendation	4

Key findings: The Trust has revised and updated the policies and procedures relevant to Lithium monitoring with approval at the relevant committees. A Lithium Care Plan has also been introduced although this is not reflected or aligned to policy in relation to methods for monitoring compliance (for example through tablet counts).

Communications regarding policy changes and the care plan have been shared through a variety of mechanisms to all Trust staff and relevant clinicians. These include global Trust-wide emails and newsletters, the Trust intranet, the Trust-wide clinical forum, the Divisional Clinical Network and other meetings. Training on medication concordance has also been incorporated into the Trust's clinical risk training programme.

Audits of patient compliance with their lithium medication have been undertaken with results from 2021 demonstrating some improvements from a baseline that was taken in 2019. Further auditing has been requested.

Residual recommendations:

Complete the cycle of audits and improvement actions until changes made are embedded in practice.

Recommendation 4

The Trust must update the 'Operational Guidance, Hull Adult Community Mental Health Teams', to clarify the role of the Consultant Psychiatrist within the CMHT, and when a medical review of a service user's care should be sought. The Trust must assure itself that this revised guidance is being followed.

Niche assurance rating for this recommendation	4

Key findings: The 'Hull Community Mental Health Team Standard Operating Procedure' (SOP) has been updated to include further clarity on the role of the Consultant Psychiatrist. In line with the findings from the independent investigation, the procedure now specifies a three-month timeframe for booking a medical review following discharge from a Community Treatment Order (CTO). There are no other set timings for Consultant reviews with these being based on individual need.

The SOP was approved by the Trust's Quality and Patient Safety Group in May 2021 and then communicated to all staff in May and June 2021. The Trust also provided evidence that the general adult psychiatrists had been informed in their meeting in May 2021 of the changes to the SOP and their responsibilities in relation to this. This included reference to the new process when discharge from a CTO is planned; an automatic date for medical review would be generated, although the reviews could still be done earlier if there was a clinical need to do so.

A Consultant review appointment within three months is included on the 'Discharge To Informal Status Form'. Monthly audits of CTO compliance between July and December 2021 showed high compliance for the case note sample, with follow up action being taken where any non-compliance was found.

Residual recommendations:

Complete the cycle of audits and improvement actions until changes made are embedded in practice.

2. Assurance summary (cont.)

Recommendation 5

The Trust should seek to agree with the police how and when it can engage with families who have been affected by a mental health homicide.

Niche assurance rating for this recommendation **4**

Key findings: The Trust has updated the Serious Incidents and Significant Events Policy and Procedure. This now includes a specific section for 'Homicides by Patients in Receipt of Mental Health Care' and supporting standards within a section titled 'Single Point of Contact and Support of those Involved'. The two sections offer clarity on the importance of involving the families of victims and the perpetrators, dependent on their preferences, and the opportunity to have a single point of contact to clarify the process of investigation and answer questions throughout.

As the Trust would be reliant on the provision of victim and family details from the police, the Trust also provided evidence of email communications with Humberside Police Force, seeking assurance that they would be contacted as soon as possible if the police become aware of any homicide involving a Trust patient. Communications specify that the contact should include information relating to the victim and their family where possible to allow the Trust to involve them in the investigation. These have been converted into Trust guidance (the Standard Operating Procedure Following Notification of a Mental Health Homicide) so that future staff and relevant postholders can refer to and understand the agreement that has been reached.

There has been a further homicide involving a mental health service user and the police. Evidence has been provided which supports early communications with the perpetrator, their family and the family of the victim. We also saw evidence of positive, collaborative relationships between the Trust and the Humberside Police Force, with assurances provided that any future engagement to support families and manage relations would be led by the Police Senior Crime Investigator roles.

Residual recommendations:

Complete the cycle of audits and improvement actions as cases allow to demonstrate that changes made are embedded in practice.

Recommendation 6

The Trust should evaluate the evidence underpinning its action plan within three months to ensure it can demonstrate to the CCG that each action has been completed, tested and embedded.

In instances where actions cannot be evidenced as closed, steps should be taken to fulfil the original commitments of the action plan within six months.

Niche assurance rating for this recommendation **4**

Key findings: The Trust provided the minutes of the meeting in October 2021 where an overview of evidence had been provided to the CCG for the action plan. The panel accepted the evidence submitted. Our review of this evidence has confirmed that actions have been completed with some evidence of testing. Audit cycles and improvement actions should continue to ensure changes made are fully embedded in practice in all cases.

Residual recommendations:

See recommendations 1-5 above.

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1

The Trust should align the 'Care Programme Approach (CPA) and Non-CPA Policy and Procedural Guidance' and the 'Operational Guidance, Hull Adult Community Mental Health Teams' so that staff are clear about the factors that must be taken into account when discharge from services has been requested or is being considered, and the operational protocols to be followed when discharge has been agreed, especially for those service users with a history of violence.

Action 1: Align policies to ensure clarity regarding the factors that must be considered when discharge from services has been requested or is being considered especially for those service users with a history of violence.

Key evidence submitted	Niche review
CPA Policy, April 2021	The CPA Policy was revised and approved in April 2021 and the version log records the amendment made regarding discharge from CPA. The Policy now requires staff to consider historic violence or aggression using a multi-disciplinary team approach prior to discharge, recording this clearly in the clinical record and discharge paperwork. If linked to their current mental health presentation, consideration should also be given to sharing this historical information with the GP and any other involved parties.
Hull CMHT SOP v5, May 2021	This document provides a change record to state that Version 4.0 had been updated with "Improvements and changes following a patient incident and learning." The SOP now includes (pages 16 and 17) a direct copy of the information from the CPA Policy, providing evidence of the action taken by the Trust to align the two documents for staff. This includes the requirement for the multi-disciplinary team to consider historic violence or aggression prior to discharge.

Action 2: Evidence required of board level or quality subgroups' oversight and sign-off of aligned policies.

Key evidence submitted	Niche review
MH Legislation Steering Group minutes, April 2021	The minutes of the Mental Health Legislation Steering Group on 21 April 2021 evidence the discussion and review of the CPA Policy amendments. These specifically reference the changes made to reflect learning from the Niche Investigation and Recommendation 1. The changes made to the CPA Policy were agreed by the group with a post-meeting note added (undated) to offer further clarity that previous violence and aggressive behaviour must be considered prior to discharge by the multi-disciplinary team (MDT) with outcomes recorded.
Quality Patient and Safety Group minutes, May 2021	The review and approval of the 'Standard Operating Procedure, Hull Adult Community Mental Health Teams' is recorded in the minutes of the Quality and Patient Safety Group for the Nursing, Allied Health and Social Care Directorate that took place on 25 May 2021. Page 10 of the minutes evidence the discussion of the SOP and refers to the changes made to edit a paragraph regarding discharge expectations, especially for those who are vulnerable and those regarding violence and aggression.

Appendix 1: Evidence review (cont.)

Recommendation 1 (cont.)	
Action 3: Evidence of communications/discussions/agenda items in Trust-wide meetings to alert staff to the policy.	
Key evidence submitted	**Niche review**
Practice Note Additions to the CPA Policy, April and July 2021 Clinical Risk Management Group minutes (including PN), April and July 2021 Two circulation emails for PN 2021-07 The Global (various communications) Hull CMHT SOP on intranet Emails (various) sharing new Hull CMHT SOP with Team Leads Mental Health (MH) Division Practice Network minutes, May and July 2021	The Trust provided 16 pieces of evidence to demonstrate that the updated CPA Policy and the standard operating procedure (SOP) had been shared with relevant staff. This included evidence to demonstrate discussion via committees e.g. the Clinical Risk Management Group (CRMG) and raising awareness across the organisation through internal Trust communications including the intranet and the Global (a weekly update containing news and information from across the Trust). A Practice Note (PN) had also been shared with all Trust staff working within the mental health and learning disability inpatient and community settings. This was distributed by the Patient Safety Team. The PN included specific information relating to the discharge of patients with a history of violent and aggressive behaviour towards others. It confirmed that this should be discussed and considered by the multi-disciplinary team (MDT) prior to discharge and recorded clearly in the clinical record and discharge paperwork. It also prompts teams to consider the risk of potential violence and aggressive behaviour and whether this might be linked to their current mental health presentation; if so, to give consideration to sharing this historical information with the GP.

Appendix 1: Evidence review (cont.)

Recommendation 1 (cont.)	
Action 4: Local and Trust-wide regular audits as evidence that operational protocols are followed when discharge has been agreed.	
Key evidence submitted	**Niche review**
Audit for Service Users Questions	This provides the questions to be audited by each of the CMHTs during the monthly audits between June and December 2021. Five questions were used for each discharge record reviewed: 1. Has the patient been discharged in the last month? 2. Was there a previous episode of violence or aggression (related to the patient's mental health presentation) known prior to discharge? 3. Is there evidence this behaviour of previous violence and aggression was discussed and recorded in the clinical record prior to discharge by the MDT? If 'No' reason in mandatory comment. 4. Did the MDT team record it was appropriate to inform the GP of these behaviours at the point of discharge? 5. Is there evidence this information is recorded in the discharge letter?
Clinical Governance Meeting minutes, August, September and October 2021	The Clinical Governance Meetings in August, September and October 2021 received audit progress updates. At the meeting in September, this reflected one record as red (not compliant) from the July audit data. The Hull CMHT Manager agreed to follow up and report back. In the October minutes, an update was provided that there had been issues found in how clinicians update a Functional Analysis of Care Environment (FACE) risk assessment on the electronic records and this had impacted the audit and clinical dashboard. The October minutes also reflect that issues had been found with some staff updating an old version of the FACE document. The full audit report similarly references this issue and states that information to the GP had been provided in the risk assessment, but not in the discharge letter, thus meeting the standard for the Policy (and recommendation) albeit by a different approach to that expected in the audit.
Service Users Questions, June – December 2021,(Individual monthly Audit results also provided for June - October 21)	The full audit report presents data from June through to December 2021. This includes results from three case record audits for each month in all seven CMHTs in the Trust. The results show 100% compliance for all except the result in July (see above notes from the Clinical Governance Meeting in September).

Appendix 1: Evidence review (cont.)

Recommendation 2
The Trust must assure itself that risk assessments and CPA documentation are kept up to date, and are of the appropriate quality, in line with Trust policies.
Action 1a: Provide detail of how the quality and timeliness of the review of risk assessments and CPA review documentation is overseen and assured within services required i.e. evidence and outcomes of any quality audits, supervision agenda items.

Key evidence submitted	Niche review
Example of clinicians' dashboard	The dashboard provides information on the reviews completed for any patients on a clinician's caseload. This is used as a guide only, with prompts for clinicians to check in a patient's records before making decisions regarding a patient's care. It offers high-level information across a range of assessments and forms, including care plan reviews and risk assessments, showing which are up to date, due within 28 days or overdue.
Hull West CMHT Audit Report: Compliance of Care Plan, FACE risk assessments and CPA, October 2021	This audit aimed to assure the Trust that risks assessments, care plans and CPA documentation are up to date and of the appropriate quality. It covers the period February 2021 to September 2021 and reviewed 146 records. These were selected at random across each clinician's caseload. Results demonstrated above 90% compliance for FACE risk assessments, care plans and CPA reviews. One recommendation and three supporting actions were included in the audit report to offer further assurance through amendments to the managerial aspects of supervision.
Hull West CMHT My Assurance Audit Report: Quality of Care Planning, October 2021	The audit report followed an initial compliance audit in July 2019 and a re-audit in September 2021. It provided results from the six months between April – September 2021. Records had been reviewed to demonstrate that care plans had been developed to the expected standard and in collaboration with patients and carers (where appropriate). Each month, there had been a random review of five records in the Hull West CMHT against the audit standards. This demonstrated above 90% compliance in four months; May 2021 showed 87.2% compliance and July 2021 showed 66.8% compliance. The audit identified areas where improvements were required. A recommendation was made to provide assurance of both patients and carers being actively involved in the care planning process in respect of care pathways and discharge planning.
Hull West CMHT Audit Report: Compliance of Care Plan, FACE risk assessments and CPA, January 2022	This repeats the audit above over the four-month period between October 2021 and January 2022. This reviewed a total of 69 records. There had been a reduction in compliance for care plans and FACE risk assessments across the period to 81% (94% in October 2021) and 86% (93% in October 2021). CPA reviews were at 100% compliance. The audit recommendation states that there needs to be further embedding of the use of Report Manager within clinical practice and to ensure this is utilised to provide further assurance of compliance. A supporting action was for staff to ensure that questions relating to this audit are asked during supervision.

Appendix 1: Evidence review (cont.)

Recommendation 2 (cont.)	
Action 1a (cont.): Provide detail of how the quality and timeliness of the review of risk assessments and CPA review documentation is overseen and assured within services required i.e. evidence and outcomes of any quality audits, supervision agenda items.	
Key evidence submitted	**Niche review**
CPA Review Compliance reports, Hull West summary report, January 2022	This report provides evidence of the Hull West CMHT performance against the completion of CPAs on at least a monthly basis between January 2021 and January 2022. This includes CPAs and clusters which have a review in date, with an average of 165 records being reviewed monthly across the period. The compliance expected for the team is set at 95% and this was met or exceeded in 11 of 15 reviews. Between 1 October and 13 December 2021 compliance fell; a recovery plan is included to support improvement. In the reviews on 29 December 21 and 04 January 2022, compliance returned to 95%.
Hull West CMHT Audit Report: Quality of Care Planning, October 2021-January 2022	The aim of the audit is to ensure that the Quality of Care Plans developed are of an expected standard and in collaboration with both the patient and carer (where applicable). The audit has highlighted improved compliance with the standards. A further evaluation of the My Assurance Audit was recommended to be undertaken in six months.
Hull West CMHT Audit Report: Risk assessments and CPA documentation, March 2022	A random sample of 14 case note reviews was audited. Action was required for three cases. A note states that these audit results are received at the Mental Health Division Governance Meeting on a monthly basis for oversight and to capture actions.
Individual Supervision Record template	Prompts on this document include caseloads, CPAs, FACE risk assessments/risk plan, vulnerability (any patients identified), care and intervention plans).

Appendix 1: Evidence review (cont.)

Recommendation 2 (cont.)	
Action 1b: Provide samples of minutes for overseeing respective governance group/s committees.	
Key evidence submitted	**Niche review**
Mental Health Services Division Clinical Governance Meeting minutes, 6 April 2021	Minutes of this meeting referenced that the clinical dashboard had been trialled for Clinical Leads in CMHTS for 12 weeks and was now live for supervisors.
Clinical Governance Meetings minutes, April to October 2021	Meeting minutes demonstrate review and discussion of the monthly audit results and updates. Meetings appeared to be well attended with representation from across corporate, professional and care leads. Meetings were chaired by the Trust's Modern Matron.
Evidence AO - Quality and Patient Safety Group minutes, May 2021	The minutes evidence an update of the homicide review work including in relation to the revised Hull CMHT SOP.
Mental Health Services Division Practice Network Meeting minutes, 1 September 2021	The clinical dashboard template was shared with the meeting as a tool for clinical supervisors and clinicians to monitor the key quality and clinical requirements of patients on their caseload. The meeting asked for checks that clinicians know it exists and whether it is being used regularly in supervision. An action was to add this as an agenda item in leadership and team meetings
Mental Health Services Division Clinical Governance Meeting minutes, 8 September 2021	Meeting minutes included reference to the clinical dashboard which was described as a valuable tool for clinical supervisors and clinicians for monitoring the key quality and clinical requirements for patients on their caseload. The meeting asked for checks that clinicians know it exists and whether it is being used regularly in supervision. An action was to add this as an agenda item in leadership and team meetings.

Appendix 1: Evidence review (cont.)

Recommendation 3
The Trust should consider, and reference in appropriate policies, the need for additional methods of monitoring compliance with Lithium to mitigate the risks of non-concordance with treatment plans for patients with a history of noncompliance and who are at risk of relapse.
Action 1: Applicable updated policies/guidance and/or SOPs that include the need for additional methods of monitoring compliance with medication to mitigate the risks of non-concordance with treatment plans for patients with a history of noncompliance and who are at risk of relapse. For example –Trust wide SOP/clinical risk policy - include other methods to check compliance i.e. clinical presentation, collecting prescriptions, asking patient, taking bloods etc.

Key evidence submitted	Niche review
Evidence J – Practice Note 2021-06 Medicines Adherence, 29 March 2021	This specifies learning from the Niche investigation with specific reference to the need for regular discussions regarding medication, determined by risk factors, and involving service users in their care to support trusting relations. It provides steps to be taken when there has been an issue with adherence previously, including the requirement to document any discussions in medical notes. The Practice Note was issued prior to the development of the Lithium Care Plan but gives steps for community teams for treatment adherence for prescribed medicines which would include Lithium.
Email circulation of Practice Note 2001-06 medicines adherence, 30 March 2021	The email was shared with all staff. This included the Practice Note on medicines adherence described above.
Evidence K - Safe and Secure Handling of Medicines Procedure V8.1 & 8.2, 8.4, May 2021	Section 23.1 of this updated procedure centres on treatment adherence with medicines for mental health conditions. This includes the steps to be taken to help patients improve adherence and prevent relapse. Examples include: • regularly reminding patients of the importance and positive benefits of taking their medication; • asking how they are doing with their medication including physical checks such as tablet counts; and • where available, involving family/carers so they are aware of the importance of the medication, side effects and possible signs of relapse which may be due to not taking the medication.
Email regarding the Safe & Secure Handling of Medicines Procedure, 6 May 2021	Confirmation from the Clinical Governance Team that this procedure has been uploaded onto the Trust intranet.
Evidence AP - MH Division Practice Network Minutes, July 2021	Minutes include that the Lithium Care Plan was shared with the meeting and that this would be supported by a Practice Note on Lorenzo.
Evidence AP - Clinical Advisory Group Minutes, July 2021	Minutes include that the Lithium Care Plan was shared with the meeting. and that this would be supported by a Practice Note on Lorenzo.

Appendix 1: Evidence review (cont.)

Recommendation 3 (cont.)	
Key evidence submitted	**Niche review**
Hull & East Riding Prescribing Committee Prescribing Framework for Lithium in Affective Disorders and Cluster Headache, July 2021	These guidelines provide a framework for the prescribing of Lithium by GPs and sets out the associated responsibilities of GPs and hospital specialists for shared care arrangements. Prescription monitoring arrangements and timeframes are included within this guidance.
Updated Lithium Care Plan, 13 September 2021	This includes monitoring of the efficacy of the medication, the times that patients should take the Lithium, the importance of compliance and risks of sudden withdrawal. It does not, however, reference the steps to take to help patients improve adherence and prevent relapse which are listed in the Safe and Secure Handling of Medicines Procedure.
Action 2: Evidence of guidance and standard operating procedure sign off.	
Key evidence submitted	**Niche review**
Drug & Therapeutics Group meeting minutes, 25 March 2021	Minutes evidence discussion of the revised Safe & Secure Handling of Medicines Procedures including addition of the Adherence Section at 23.1 regarding the importance of checking treatment adherence for mental health service users. Options for audit to check staff compliance with the procedure were also discussed.
Evidence AC – Mental Health Services Division Practice Network meeting minutes, 5 May 2021	Minutes of this meeting include that Practice Note 2021-06 Medicines Adherence was shared with the meeting. The minutes also captured a discussion about the requirements for audit and the challenges this would present to Clinical Leads. A decision was made to further discuss this with feedback to the group once audit criteria had been agreed.
Evidence AO – Quality and Patient Safety Group minutes, May 2021	Minutes confirm approval of the Hull CMHT SOP.
Evidence AD - The Global including Quality Five-Minute Focus Update, May 2021	This Global update from the Quality and Patient Safety Group includes reference to the approval of the revised Hull CMHT SOP.
Evidence AJ – Email from Service Manager to Clinical Leads, 22 June 2021	This email confirms that the revised Hull CMHT SOP has now been approved, signed off by the Quality Patient and Safety Group and is on the intranet.
Evidence AD - SOP on Global, 23 June 2021	This shows that the revised Hull CMHT SOP is on the Trust intranet.

Appendix 1: Evidence review (cont.)

Recommendation 3 (cont.)	
Action 3: Evidence of communication to staff	
Key evidence submitted	**Niche review**
Evidence M – Practice Note 201-06 Medicines Procedure	Evidence of communications to staff through Trust-wide emails and newsletters, the Trust intranet, the Trust-wide clinical forum, the Divisional Clinical Network and other meetings.
Evidence N - email sharing Practice Note 2021-06	
Evidence AC – Divisional Practice Network minutes 5 May 2021 inc PN 07 shared	
Evidence AX - 5 Minute Focus Treatment adherence to medicines	
Evidence BC – Practice Note 2021-24 Lithium Compliance	
Evidence BC - email circulation for Practice Note 2021-24 Lithium Compliance	
Evidence BC – Clinical Risk Management Group minutes approving Practice Note 2021-24 Lithium Compliance	
Evidence BK – Practice Note 34 launch of Lithium Care Plan	
Evidence BK – communication email of Practice Note 34	
Evidence BL – Global communication including launch of Lithium Care Plan	
Evidence BM – MS Teams Diary Drop in sessions in diary – Lithium Care Plan	
Evidence BN - email sharing Practice Note 34 and communications to Practice Network	
Evidence BN - email sharing Practice Note 34 & comms to Governance	
Evidence BO – Practice Note 35 carers as service users - changes to Lorenzo	
Evidence BO - communications email of Practice Note 35	
Evidence BP - email sharing Practice Note 35 and communications to Practice Network	
Evidence BP - email sharing Practice note 35 and communications to Governance	
Evidence BR - Global Newsletter including Lorenzo alert and recording ability for carers as a service user, 15 December 2021	
Evidence BN - Consultants and Senior Leads agenda and meeting minutes,16 December 2021 - Lithium Care Plan	

Appendix 1: Evidence review (cont.)

Recommendation 3 (cont.)	
Action 4: Evidence of incorporation into existing clinical risk training	
Key evidence submitted	**Niche review**
Evidence AK - email to Division about ESR Clinical Risk Training, June 2021	E-mail advising staff of the Clinical Risk Training and how to enrol on it.
Evidence AY - Medicines Incidents and Lessons Learned Quiz (undated)	This presentation is part of the training regarding medication compliance, and to include therapeutic levels being considered for drugs where this is monitored (such as Lithium).
Email from Non-medical Prescribing Lead/Lead Medicines Optimisation Nurse, September 2021	Update advises that medication awareness training would be available on ESR (from 9 May 2021); and that therapeutic monitoring is discussed within the Medicines Optimisation Training.
Evidence BE - Clinical Risk Train the Trainers 28/29 - Training slides, September 2021	This training includes the risk of non-adherence to prescribed medication.
Evidence BQ - Clinical Risk Training staff enrolment, December 2021	Enrolment numbers for two training sessions held in December – a total of 15 mental health staff enrolled.
Action 5: Dip samples/case note review to show compliance with guidance/SOP	
Key evidence submitted	**Niche review**
Lithium Quality Improvement Audit, October 2021	This audit aims to improve the quality of monitoring of lithium, to identify non-compliance with the shared care framework for lithium, and to identify if improvements have been made over the last two years. Results demonstrated some improvements, with 28 patients out of 31 compliant (90.3%) with their medication in 2021.

Appendix 1: Evidence review (cont.)

Recommendation 4
The Trust must update the 'Operational Guidance, Hull Adult Community Mental Health Teams', to clarify the role of the Consultant Psychiatrist within the CMHT, and when a medical review of a service user's care should be sought. The Trust must assure itself that this revised guidance is being followed.

Action 1: Updated operational SOP that clarifies the role of the Consultant Psychiatrist within the CMHT, and when a medical review of a service users care should be sought.

Key evidence submitted	Niche review
Hull Community Mental Health Team – Standard Operating Procedure, May 2021	This SOP was revised and approved in May 2021. A section on page 8 sets out the role of the Consultant Psychiatrist within the CMHT. This includes to: • ensure a three-month Consultant follow-up appointment is made with the patient following discharge of CTO; and • provide assessment and review of patients based on individual need.
Quality and Patient Safety Group minutes, May 21	Minutes provide evidence that the Quality and Patient Safety Group received and approved the revised Hull CMHT SOP.
Trust intranet pages and Trust Global briefing, May and June 2021	Documents evidence the Trust had communicated the new SOP to staff including upload to the intranet and sharing on the Global (internal communications briefing).

Action 2: Need evidence of the process of booking a medical review of a patient with a Consultant when an individual has been taken off a CTO, to include timescales for review to be undertaken.

Key evidence submitted	Niche review
General Adult Psychiatrists Meeting minutes, 13 May 2021	Minutes include reference to a communication that the SOP is being updated to include the process of discharge from CTO and that this will generate an automatic date for medical review within stipulated time frames or earlier if clinically required.
Discharge to Informal Status Form	This form includes a question asking if a patient has been discharged from a CTO and whether a follow up Consultant review appointment has been arranged within three months of discharge.

Appendix 1: Evidence review (cont.)

Recommendation 4 (cont.)	
Action 3: Audit the number of medical reviews following discharge from CTO undertaken and how many were undertaken within the specified time.	
Key evidence submitted	**Niche review**
General Adult Psychiatrists Meeting minutes, 8 July 2021	The new monthly audits of medical reviews were discussed. These highlighted three record reviews, with two discharges being on an old version of the Section 23 Form (used to record discharge from CTO) and one form with no Section 23 completed. The Chair of the meeting asked for all members to be aware of the requirements to use the new form and to arrange a medical review appointment as required.
CTO Compliance Audit Report, January 2022	The audit provided evidence of compliance in three areas for service users discharged from CTO by the Trust: 1. Use of the correct form. 2. A three-month review has been completed. 3. The review has been rebooked if the person did not attend. This was audited on a monthly basis between July and December 2021 with two to three patients per month being discharged from CTO. The audit provides information on each of the cases reviewed including any follow-up action taken.

Appendix 1: Evidence review (cont.)

Recommendation 5
The Trust should seek to agree with the police how and when it can engage with families who have been affected by a mental health homicide.
Action 1: Information in relation to homicide post the incident with Ms C showing how the police now work with us to ensure we are able to fulfil being open and transparent with families that are affected

Key evidence submitted	Niche review
Serious Incidents and Significant Events Policy and Procedure, October 2019	This includes a specific section for 'Homicides by Patients in Receipt of Mental Health Care' and has supporting standards within a section titled 'Single Point of Contact and Support of those Involved'. The two sections offer clarity on the importance of involving victims and their families, depending on their preferences, and the opportunity to have a single point of contact to clarify the process of investigation and answer questions throughout.
Duty Of Candour letters, November 2019 and April 2020	The Trust provided evidence of the Duty of Candour letters for a homicide that involved a mental health service user in September 2019 (subsequent to the incident involving Ms C). Letters were sent to the perpetrator, their next of kin and the victim's family two months later. Letters confirm that the Trust would be completing an investigation with an invitation for the perpetrator and families to be involved. Follow-up letters April 2020 offered a copy of the final report.
Emails to Humberside Police, 15 February 2021	The email exchange between the Trust and the Mental Health Coordinator in Humberside Police Force confirms the Trust's understanding of the expected process for sharing victim and family details in the event of a homicide.
Correspondence with Police, 6 October 2021	This evidenced further communication to seek information relating to any policies or processes in Humberside Police Force which may be relevant to this recommendation. The police confirmed there was not a documented procedure but that Police Senior Crime Investigators would be responsible for working with the Trust and families to manage relations.
Standard Operating Procedure Following Notification of a Mental Health Homicide, July 2022	This SOP was approved at the Trust's Clinical Risk Management Group. The document details the steps the Trust will take following notification of an alleged homicide committed by a patient in receipt of mental health services (or recently discharged from these). It includes how the Trust will obtain the victim's next of kin details from the police so that a Duty of Candour letter can be sent with an invitation to participate in the Trust's investigation and steps to be taken if no response is received.

Appendix 1: Evidence review (cont.)

Recommendation 6

The Trust should evaluate the evidence underpinning its action plan within three months to ensure it can demonstrate to the CCG that each action has been completed, tested and embedded.

In instances where actions cannot be evidenced as closed, steps should be taken to fulfil the original commitments of the action plan within six months.

Action 1: Evidence of CCG closure.

Key evidence submitted	Niche review
Hull CCG & East Riding of Yorkshire CCG Collaborative Serious Incident Panel Meeting minutes, 22 October 2021	The Trust provided the minutes of the meeting held in October 2021 where an overview of evidence (as described on the previous pages of this assurance report) had been provided to the CCG for the action plan following the homicide. The panel accepted the evidence submitted by the Trust to show the actions that had been embedded.

See also the evidence submitted for Recommendations 1-5 on previous pages.

Appendix 2: Glossary of terms

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CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CRMG	Clinical Risk Management Group
CTO	Community Treatment Order
DTG	Drugs and Therapeutics Group
FACE	Functional Analysis of Care Environment
MDT	Multi-disciplinary team
NIAF	Niche Investigation Assurance Framework
PN	Practice Note
SOP	Standard Operating Procedure

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