FACEREMELIUS

INDEPENDENT ASSURANCE REVIEW

A critical analysis and assessment of a mental health trusts internal investigation of the care and treatment received by MB prior to homicide in May 2019

Summary report

January 2024

Section 1: Contents

Section 2: Introduction

2.1 MB (anonymised initials) lived with his elderly relatives from a young age and was in receipt of services from a local mental health provider (the trust) between 2012 and the incident May 2019.

2.2 In May 2019, MB was arrested and charged with the murder.

2.3 MB was remanded to a local category B prison and subsequently convicted of murder in December 2019; he was sentenced to 26 years.

2.4 In October 2021, NHS England formally commissioned Facere Melius (FM), a healthcare consultancy, to undertake an independent quality assurance review of the care and treatment provided to MB prior to the incident of homicide in May 2019. This review was commissioned in line with NHS England's Serious Incident Framework (2015) and the terms of reference provided to the FM team (see appendix one).

Section 3: The incident of homicide

3.1 MB had a long forensic history, with mental health problems from 2012, and a history of poly-substance misuse, including alcohol. He was diagnosed with depressive disorder, with recurrent suicidal thoughts and a tendency to self-harm. He was later diagnosed with acute polymorphic psychosis, and in 2016 with paranoid schizophrenia.

3.2 MB had support from community treatment teams, and had eight admissions to inpatient units, including detentions under the Mental Health Act (MHA) Section 5 (2), under the MHA Section 2, and Section 3 (see glossary and references). He was subject to Community Treatment Orders (CTO) following inpatient discharges. He was discharged from his Section 3 in August 2018 on a CTO, which was revoked in February 2019. The rationale by his clinical team was that due to MB refusing depot medication as he reported side effects, and his switch to oral medication which did not require regular appointments, he no longer required the CTO. He did not adhere to the terms of the CTO. He did not consistently attend appointments and showed a lack of engagement when he did. This non-adherence was not, on balance, considered a risk by the clinical team as historically he had self-referred when his condition worsened.

3.3 Prior to 2019, MB had significant contact with the local police having been linked to several violent incidents, although he was not charged in connection with these offences. This included seven incidents recorded as domestic abuse. The most

serious incident involved the stabbing of a close family member who received wounds to their body and head during an assault in January 2017.

3.4 MB was to be readmitted to an acute admission ward in May 2018 as he was not compliant with his CTO and was reported as missing from hospital. On this date, a nurse from the day unit contacted the police. The nurse reported that MB had informed the unit that he had to stop himself from killing a man during a fight. MB had also made threats to stab himself and any others who came to his door. In July 2018, a member of the crisis team informed the police that MB had told their staff that he had been thinking about harming himself and others, and had been carrying weapons.

3.5 In March 2019, MB's next of kin raised concerns during a home visit by trust staff that he had been associating with a man who had recently been released from prison and who used illicit drugs.

3.6 In May 2019, the Police Intelligence Unit contacted the trust for information regarding a suspect, namely MB. MB was apprehended later that evening and arrested for homicide.

Section 4: Condolences and thanks

4.1 The FM review team would like to express their sincere condolences to the family of the victim and express their understanding that this event will have had a significant impact.

4.2 The family and friends of the victim did not engage with this review, and did not respond to attempts to contact them, made by NHS England or the FM review team.

4.3 The review team would like to acknowledge and appreciate the cooperation of MB and his family for providing insight into the care and treatment MB received from mental health services prior to the incident. They are aware of how difficult it was for them to talk about this matter, however the insight gained from these conversations was invaluable to its understanding of events.

4.4 The review team would like to thank those staff from the trust who met with them and engaged in the process, as well as managers who enabled the interviews to take place.

Section 5: Assurance review terms of reference and methodology

Assurance review terms of reference

5.1 The draft terms of reference were agreed on 4 November 2021 at an initiation meeting held by NHS England (see appendix one). The meeting was attended by Facere Melius, and those agencies involved in the trust's serious incident investigation into the care and treatment of MB.

5.2 The purpose of the assurance review was to:

- undertake a desktop review of the internal investigation into the care and treatment of MB undertaken by the trust.
- to determine whether the internal investigation lines of enquiry were robustly considered and explored, highlighting any areas requiring further examination.
- based on review findings, formulate recommendations which would lead to sustainable and measurable improvements.
- to identify and communicate any early learning opportunities determined throughout review activities and what is expected to change as a result.

5.3 FM's review has carried out a critical analysis of the internal investigation's approach and key lines of enquiry to determine if these were appropriate at the time it was commissioned, if they were adequately explored during the investigation, and highlighting areas requiring further investigation.

Facere Melius assurance review methodology

5.4 The FM review team used a range of qualitative and quantitative techniques and methodology to undertake the review. They examined all the available records relating to the internal investigation conducted into the care and treatment provided to MB. This process included:

- Review of 527 submitted documents, including but not limited to:
  - internal trust investigation report
  - investigation terms of reference
  - trust action plan
  - clinical notes
  - police records
  - interview notes

- Review of national policies, local policies and guidance:
  - delivery of care
  - managing complex cases
  - learning from incidents
  - single point of access
  - care programme approach
  - risk management and planning

5.5 The assurance review team met with MB's family on two occasions: 11 May and 15 June 2022. And met MB via video link on 6 October 2022.

5.6 The review team interviewed staff, including senior management staff from the trust community services, the crisis and liaison team, and a consultant psychiatrist. The team met with the lead investigator and author of the serious incident investigation report.

5.7 The FM review team used its own quality and assurance frameworks as tools to assess the approach taken by the trust in conducting its internal investigation, and their subsequent report, recommendations and action plan.

5.8 The FM quality framework was used to review the trust's report, focusing on a number of areas including:

- terms of reference
- engagement with stakeholders
- report authors and experience
- methodology and appropriateness of approach
- alignment and appropriateness of findings and recommendations

5.9 The FM assurance framework was used to assess the action plan developed by the trust. Each action is assessed against criteria:

- effectiveness of implementation
- maturity of implementation
- quality of assurance

5.10 Further details are provided in appendix two.

5.11 Before drafting the report, a team of independent advisors provided the FM review team members with additional support, guidance, analysis, and expert opinion. This included giving advice on whether professional practice was in line with national or local guidelines and good practice in their specialism. The draft report was then reviewed, and quality assured by a Facere Melius advisory board, whose members provided the authors with feedback, having undertaken an objective enquiry and rigorous evaluation of their work.

5.12 On completion of the review, the draft report was shared with the trust and other stakeholders as part of the factual accuracy process. All stakeholders were consulted on recommendations before publication of the report.

Section 6: FM assurance review team

6.1 The assurance review team consisted of lead reviewer, patient safety advisor, mental health and substance misuse advisor and police advisor.

6.2 The advisory board consisted of senior associates, editorial standards advisor and director.

Section 7: Review of the trust's internal serious incident investigation, and assessment of the adequacy of its findings, recommendations and action plan

7.1 The FM review team has assessed the trusts investigation report on the care and treatment provided to MB. They have used the FM quality assurance framework as a tool to establish whether the internal independent investigation was robust, appropriate, and complied with best practise and both local and national policy in place at the time of the investigation. A number of areas for improvement were identified, and a detailed assessment of these is in appendix three. A summary of the main points from this evaluation is given below.

7.2 The review team also considered the trust's initial response to the incident and the sharing of learning through an after-action review.

After Action Review (AAR)

7.3 An after-action review (AAR, see glossary and references) is a structured approach for reflecting on the work of a group and identifying strengths, weaknesses and areas for improvement following an incident. This is held with the team and professionals involved in the care of the service user(s) involved.

7.4 AAR aims to capture learning that is widely disseminated so that good practice can be shared and changes made to reduce the likelihood of recurrence where something has gone wrong. It usually takes the form of a facilitated discussion following an event or activity. It enables understanding of the expectations and perspectives of all those involved, and it captures learning, including any immediate learning, which can then be shared more widely.

7.5 The trust carried out an AAR on 2 September 2019 to review the incident and identify key actions required to reduce the risk of similar events happening again and agree how the learning would be shared.

7.6 A list of staff roles to identify those having participated in the learning session was included in the AAR report:

- Clinical manager

- Clinical lead
- Pathway manager
- Consultant psychiatrist
- Crisis team NMP (non-medical prescriber) lead
- Support worker
- Representative from Criminal Justice Liaison team
- Incident investigating officer
- Lead clinician

7.7 The AAR report showed that the trust offered support to the perpetrator's family as part of its immediate response. The report stated that the clinical manager and associate nurse director conducted a sensitive debrief with staff involved in MB's care; this was to be followed by regular supervision to ensure they received ongoing support.

7.8 The report of the AAR is comprehensive and demonstrates that progress notes relating to the case were examined with learning opportunities explored. Risk assessments, a brief psychiatric and physical history of the patient and medication prescribed were all considered. A number of key learning points were identified from the AAR which are summarised as follows:

- Ensure all patient documentation is up to date, contemporaneous, and reflects current needs
- Ensure staff are supported to maintain contemporary notes through case management supervision
- Ensure staff know how to complete risk assessment
- Consider a multi-disciplinary system of review where risk ratings are 2 and above
- Ensure each case is reviewed in supervision at least annually
- Ensure the MIG (medical interoperability gateway) is checked at CPA, or following changes to medication
- Inpatient and community Responsible Clinicians to have a clinical discussion when a patient is being discharged on a CTO
- MDT formulation meetings to be considered for all patients who present with complex mental health needs

7.9 Key actions were also agreed:

- Staff to be reminded of the organisation and regulatory bodies standards regarding documentation and the rationale for this.
- Robust clinical and caseload supervision would support individuals in care planning and maintaining standards of documentation.
- Teams to ensure the MIG is checked at CPA, or following changes to medication to prevent medication errors occurring and improve communication with GP.

- Recommendation for a clinical discussion to occur between inpatient and community Responsible Clinicians when a patient is being discharged on a CTO to ensure agreed rationale for CTO and continuity of care.
- MDT formulation meetings to be considered for all patients who are presenting with complex mental health needs when there is also a dual diagnosis/significant risk history/diagnostic uncertainty/disengagement and/or non-concordance. This forum could also be used when there is consideration of discharge from CTO to evidence MDT involvement to support the Responsible Clinicians decision making.

7.10 It is not clear from the report how this learning was to be shared with staff or how the actions were to be implemented. No timeframes were attached to the actions and the AAR action plan template had not been populated. The trust however clarified that AAR action plan templates are only completed for those incidents that will not proceed to a serious incident panel review. The learning points and actions from the AAR process can be recognised in the serious incident report findings; however, any delay in disseminating learning from incidents or making improvements potentially puts service users, staff, and others at increased risk. The FM review team was told that immediate learning is disseminated through locality safety and learning lessons groups.

7.11 The review team understands that learning is shared via the Serious incident (SI) group and the Trust Safety Group (TSG). The action plan is noted as being signed off at SI group (7 November 2019), however the review team have not seen evidence of the detailed learning from this case being presented to the relevant groups, committees and boards within the trust.

7.12 The trust board papers (August 2019), detail that the Quarterly Safer care report (Q1 April – June 2019) was presented and discussed. Although there is reference to two homicides in Q1 2019, there is no detail that enables triangulation with this case. There is reference to a wider thematic review, which the review team have not been provided with.

'*These two incidents along with two previous reported homicides are currently the subject of a thermatic [sic] review by Patent Safety at the direction of BDG Safety.'*

7.13 Subsequent reports to the trust board contain no detailed learning or recommendations. It is noted by the review team that the Safer Care reports provided to the board from March 2020, now have the addition of a section titled 'Learning from incidents', which is viewed as a positive step to highlighting how learning is shared across the trust following the investigation of adverse events.

Review of the internal investigation's terms of reference

7.14 The terms of reference (ToR) and methodology for the investigation by the trust were drawn up in accordance with the NHS England Serious Incident Framework (2015) and the trust's relevant policies (including its incident policy, the management of serious incidents 2016). They did not provide, however, a comprehensive and detailed framework with which to undertake the investigation.

7.15 The ToR set out the period of time which the investigation was to explore: between 2012, when MB first came into contact with the trust, and the date of the homicide in May 2019. It was conducted as a level two investigation, as reported to the FM review team by the trust's head of clinical risk and investigations, but the level of investigation was not clearly stipulated in the ToR. There is no indication of who approved the serious incident investigation and the ToR, or who drafted them.

7.16 The trust's approach to the terms of reference is to have specific bespoke lines of enquiry relevant to the case, and general ones that are included in all their serious incident investigations. The latter are more process driven and relate to areas such as developing a chronology, providing a written report, and so on. For this investigation there were eight specific terms of reference.

7.17 The time frame for completion of a level two investigation at this time was 60 days from when the incident was reported (as set out in the national serious incident framework, 2015), but the ToR did not address this requirement, or set out how any delays in completing the investigation would be communicated. The trust's serious incident policy does not include reference to the national time frame for completing investigations, or set out the local agreed time frames for the completion of investigations. The trust's incident policy practice guidance notes (dated 2012), which support investigations, state that a draft report must be submitted for a quality review within 25 days, that the report should be ready for authorisation within 30 days, and that all actions arising from the investigation are to be completed within 60 days. The national serious incident framework (2013) was amended and revised in 2015. The trust's guidance note is therefore out of date.

7.18 The ToR did not set out an internal process for the quality assurance or review of the report as part of the trust's internal governance processes before being submitted to the clinical commissioning group (CCG) for final approval, or for the monitoring of its progress, approval or dissemination of the report's findings, recommendations and actions.

7.19 The trust's investigation team appear to have made attempts to involve the families of both the perpetrator of the homicide and the victim. The review team were told that the investigating officer contacted MB's aunt who indicated the family would be happy for a home visit to be arranged. The FM review team were unable to

determine the exact nature and outcome of the contacts described and it is therefore unclear if the families were offered the opportunity to raise any concerns or questions for the trust's investigation team to consider. The trust did contact MB's family to offer support, but the family declined and asked for no further contact. There is no indication within the investigation report that contact was made with MB at the time of the trust's internal investigation.

7.20 There is no evidence that there was any collaboration with other stakeholders, such as the police, commissioners, or MB's GP, about the development of the ToR. The serious incident framework (2015) encourages healthcare organisations to work collaboratively to inform systematic learning and improvement.

Commentary

C1. The use of after-action review (AAR) is an example of good practice by the trust. It was carried out promptly following the incident of homicide. The review event was well attended by staff. It correctly considered the support of the perpetrator's family and staff involved in MB's care. The resulting report is comprehensive and demonstrates the thoroughness of the process in identifying both learning points and key actions. Whilst these were recognised in the subsequent serious incident investigation report, it was not clear from the documentary evidence provided by the trust that they were acted on promptly to reduce the risk to other service users, trust staff and the wider community.

C2. As noted above, there were a number of omissions in the drafting of the ToR and the conduct of the investigation. An important aspect of serious incident investigations is clarity of purpose and methodology, and taking the necessary time to ensure that these provide a sound basis for the investigation. It is also vital that they are appropriately approved at a senior level so that there is authentication and validity of the process.

C3. Changes in national guidance that affect operational processes should be fully and accurately reflected in organisational policies within a short period. The trust's serious incident policy and its investigation policy guidance did not include reference to national or local guidelines on timeframes for completing investigations. The guidelines had not been updated since 2012. Policies and guidelines are tools staff use to direct and support their work; it is important that they are kept up to date and clearly reflect national policies.

C4. The ToR did not set out the governance processes and methods of updating and tracking progress of the delivery of the investigation in a timely and responsive manner. This would have weakened the investigation process. For example, the 60 working days requirement enables commissioners and

providers to monitor progress in a consistent way. This also provides clarity to service users and families about the progress and expected completion date of the investigation.

C5. There was little evidence of the involvement of the families of the perpetrator and the victim, or other stakeholders, in the drawing up of the ToR. This meant that there were limited opportunities to develop and agree areas of focus in the collaborative spirit required by the serious incident framework (2015).

C6. Trusts should comply with the statutory duty of candour set out in Regulation 20, Duty of Candour (*Health and Social Care Act 2008 [Regulated Activities] Regulations 2014*). The aim of this is to ensure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. The trust should therefore have clarified what efforts it made to contact the families concerned, and the nature of those contacts, to demonstrate that they were complying with the duty of candour.

A review of the internal investigation's methodology

7.21 The serious incident framework recommends the use of tools such as root cause analysis (RCA) and human factors methodologies in investigations, and these are cited in the trust's terms of reference. The investigation was undertaken by an experienced independent investigator with a mental health practitioner background, and expertise in the use of RCA. The report, however, does not outline his qualifications, skills or experience.

7.22 There is little evidence in the investigation report that these tools (RCA and human factors methodology) were sufficiently and effectively deployed as a means of establishing findings or recommendations. The only reference to human factors is made in a subsection of the report headed 'contributory factors/associated factors', indicating that these are considered of secondary significance. Tools and techniques used in these methodologies, such as National Patient Safety Agency contributory classification, or five-whys, ensure that multiple factors are considered, including, for example, patients, staff, tasks, communication, equipment, environment, organisational influences, education, training and teams. Consideration of this broad range of factors ensures a thorough review, and supports the development of recommendations which identify changes and actions that will produce a greater impact.

7.23 The ToR and the investigation report included reference to trust policies and areas of focus as part of the investigation. This included policies for the clinical risk management system, including a frequently asked questions document (March 2019), the Care Programme Approach policy and incident policy guidance notes. A

review of the adequacy of risk assessments, care plans and communication between teams was also included in the ToR.

7.24 A number of the trust's staff were interviewed as part of the internal investigation, but there was no indication in the report of their roles. MB's GP was asked to produce a report, but this was not available at the time the trust was conducting its internal investigation. A pharmacy review was also considered in the internal investigation, and once completed was to be added as an addendum to the investigation report. The FM review team was not provided with evidence that either of these documents was completed. The review team was told that the lack of engagement from the GP was reported to commissioners.

Commentary

C7. The limited evidence of the use of root cause analysis or human factors methodologies in the report weakens the logical basis and analytical framework of how the findings and recommendations were established.

C8. There should be a clear indication of the investigator's qualifications, skills, experience and training in root cause analysis tools and techniques, and human factors. This would provide assurance of their suitability to undertake serious incident investigations.

C9. The terms of reference included the need to review the adequacy of the risk assessments and communication between teams. This requirement was not however adequately addressed in the report. The consequences of this are discussed in section 8 below.

C10. The omission of roles of staff interviewed in the investigation means that it is not possible to verify the accuracy and validity of what was disclosed, and therefore of the findings, conclusions and recommendations arising from them.

C11. The patient safety incident response framework (PSIRF) was launched in August 2022. This signalled a fundamental shift in the way the NHS responds to patient safety incidents. It represents a divergence from the use of root cause analysis. Instead, patient safety incident response is to be placed within a wider framework for improvement, prompting a significant cultural shift towards systematic patient safety management. As part of the introduction of PSIRF, organisations will need to ensure that all relevant staff are trained, and have developed the expertise to provide assurance regarding the new approach to investigations.

Assessment of the adequacy of the findings of the internal investigation

7.25 The internal investigation reviewed the history of MB's care and service from the trust from 2012, and then focused on the two-year period leading up to the offence. MB's contact with the mental health services included admissions to acute psychiatric wards and psychiatric intensive care wards. Primary care and mental health community treatment teams were also involved in his care and treatment. MB had an extensive psychiatric history; he was diagnosed with paranoid schizophrenia in 2016, identified as a risk of violence to others, and as a person who misused a number of substances, including alcohol. He was known to deal in illicit drugs, and was considered vulnerable. At a Mental Health Act tribunal in 2017, consideration was given to whether MB's diagnosis should be that of drug-induced psychosis, or a personality disorder.

7.26 As part of the internal investigation, MB's clinical records were reviewed, and these showed that he carried weapons and had an extensive forensic history. He had been placed on a community treatment order (CTO) on his discharge from hospital in August 2018 to ensure he complied with his depot medication (a slow-release form of medication by way of injection). A CTO is an order made by the service user's responsible clinician to ensure supervised treatment is provided for them in the community, rather than in hospital. It can assist in making sure service users attend regular appointments, but because MB did not always attend appointments, and was therefore not receiving his medication regularly, the CTO was removed in February 2019.

7.27 During the period between March 2019 and the offence, the FM assurance review team was told in its interviews with trust staff that MB would only engage with services to secure the continuance of his personal independence payments. He did not engage with therapeutic treatment or support to help him abstain from taking illicit drugs. He was also very keen to continue his anti-anxiety medication and actively sought more of this medication on more than one occasion.

7.28 The internal investigation reported that staff found managing MB's aggressive demands for medication difficult. He would frequently contact the crisis team saying that he was hearing voices. When the team contacted his family, however, they informed staff that MB was sleeping well and going out with friends.

7.29 The internal investigation found that in March 2019, MB's family twice reported concerns that he was associating with a man who had recently been released from prison and was using illicit drugs. Although the crisis team shared this information with the Initial Response Service (IRS), apart from stopping home visits no further action was taken because of the increased perceived risks posed by MB's association with this individual.

7.30 When MB was hospitalised, a family member was closely involved in his care and care planning. Not extending this family member's involvement to his care while he was in the community was a potential missed opportunity.

Commentary:

C12. The trust report identifies some contributory factors/systems and human factors relating to MB's care and treatment. These were not, however, explored in any depth:

- Management plans did not reflect his current presenting risks; his last plan was dated April 2018. Risk assessments are an important tool for staff to understand the risks an individual poses to themselves or others. It is therefore essential that they are kept up to date and include the most relevant and recent information.

- The internal investigation report stated that the clinical risk assessments were copied and pasted, but the FM review team found, from interviews with trust staff, and from a demonstration of the clinical risk management system, that this is incorrect. When a service user's risk assessment information is updated, the previously recorded information about them is automatically replicated in this new entry, and the user has the opportunity to add to or amend what had been recorded in the previous risk assessment. This control is an important feature that ensures that the previously recorded information is not lost when updates are entered. It is important that trust staff who use this system, and those who undertake internal investigations, understand how it works. The trust clarified that serious incident review panel members were aware of this when the report was presented, and the action was developed accordingly.

C13. The trust's report did not clearly identify any associated contributory or human factors to explain why MB's risk management was not more robust. The after-action review (AAR) meeting that took place with MB's team in September 2019 concluded that a multi-disciplinary approach would have been beneficial in this case to formulate a plan for a patient with complex needs.

C14. The investigation stated that while he was living with family members, MB was known to associate with a person recently released from prison and using illicit drugs. His risk profile was also recorded as enhanced or significant, and home visits were stopped. The report does not fully explore these events and risks, or actions that could have been taken as a

consequence, such as a safeguarding referral, or a carer's assessment for his family to identify any support or advice they might have needed. A professionals' multi-disciplinary meeting could have been held to review alternative methods and routes to contact MB.

Assessment of the adequacy of the recommendations of the internal investigation report

7.31 The trust's internal investigation report makes no recommendations based on significant findings, but does state that additional learning was noted, and this forms the basis of seven recommendations and related actions. Some of the investigation's findings were not incorporated into the recommendations, such as:

- recording in electronic clinical records, including the medication and allergies and sensitivities form, had not been updated to reflect the current prescribed medication
- the risk management plan had not been updated since 2018
- the 'getting to know you' section in the electronic clinical records did not indicate that any support had been offered to the family members with whom MB was living

7.32 As the investigation was internally focused, the report and recommendations do not consider the impact of the incident and investigation on local or national policy or approach. This should be explored further to ensure the learning from this incident is shared system-wide.

7.33 The report set out both recommendations and actions, which were subsequently translated into an action plan by the trust.

7.34 The report does not explain how learning will be shared and embedded into clinical practice. There is no methodology for ongoing monitoring of changes described or how the impact of quality improvements will be assessed.

Commentary

C15. The seven recommendations were in fact summaries of findings in the report, such as a missed opportunity or an event that did not happen. The 'actions' recorded underneath each of these numbered findings conflated recommendations and actions, and did not always arise logically out of the findings. They were based mainly on processes, and therefore their impact would be low. They were not focused on outcomes, or sufficiently specific to comprehensively address the issues arising from this incident, and the findings from the investigation.

C16. There are several examples (identified above) where the recommendations and associated actions do not fully capture some of the investigation's significant findings. This would have weakened the validity of the investigation, and reduced opportunities to make improvements or changes in practice.

C17. There is no evidence of others being involved in the development of the recommendations, such as MB's GP, the clinical commissioning group, or other agencies that might have come in contact with him. This would have been good practice and provided an opportunity for wider learning beyond the trust.

C18. There is no systematic governance process provided to monitor the implementation of the recommendations and their associated actions.

Assessment of the adequacy of the implementation of the action plan arising from the internal investigation

7.35 The FM review team has assessed the quality and impact of the implementation of the action plan produced by the trust in November 2019 arising from the investigation report recommendations. To achieve a comprehensive assessment, the review team used an analytical framework that enables a systematic assessment of its findings. The team considered the evidence provided by the trust, and information from staff interviews to make an assessment against the following three measures:

1. effectiveness of intervention or action (in terms of having effected positive change)
2. maturity of the implementation of the actions
3. quality of assurance

7.36 The first measure has been adapted from the Hierarchy of effectiveness of risk-reduction strategies (Institute for Safe Medical Practices, June 2020). This approach assesses the human and systems reliability of each action, and how effective they are likely to be in addressing the identified issue.

7.37 The second measure takes account of the evidence that the trust has given the review team to demonstrate the achievement of the action. From this evidence, an assessment is reached on how well the action plan has been implemented.

7.38 The third measure is based on the four lines of defence framework. This framework is designed to help organisations analyse the overall strength of their internal control, supervision and review processes (ref: Institute of Chartered Accountants in England and Wales (ICAEW): four lines of defence). It helps to identify and understand the different contributions from the various sources of information and evidence that are used, and how each one helps support the overall level of assurance. Examples of the four lines of defence are as follows:

- **First line:** the way risks are managed and controlled day-to-day. Assurance comes directly from those responsible for delivering specific objectives or processes.
- **Second line:** the way an organisation oversees the control framework so that it operates effectively. The assurance provided is separate from those responsible for delivery, but not independent of the management chain, such as risk and compliance functions.
- **Third line:** objective and independent assurance, for example internal audit, providing reasonable (not absolute) assurance of the overall effectiveness of governance, risk management and controls.
- **Fourth line:** assurance from external independent bodies such as the external auditors or other external bodies

7.39 The actions described in the trust's action plan have been assessed as likely to be the easiest to implement, but the least effective in terms of reducing the risk of recurrence. This is because they rely mainly on changes in human behaviour, rather than strengthening systems. Potential actions which could be viewed as more effective, although harder to implement, are those that include introducing an element of task automation in a system. Barriers and forcing functions within systems to help prevent human error can also prove effective. Such factors can ensure consistency in the quality of tasks carried out, particularly in situations where there is a high probability of variation or error in the ways in which people might carry out those tasks.

7.40 It is noted that for the seven recommendations within the trust's investigation report, recommendations two and six, have three actions assigned; the remaining five recommendations have one action assigned.

7.41 A summary of the review team's findings of the progress that has been made is set out below, along with areas where further work and progress are needed. A more detailed assessment can be found in appendix four.

Figure 1: Summary table using FM assurance framework

Recommendation / Action(s)	Effectiveness of Intervention	Maturity of implementation	Quality of assurance
1			
2			
3			
4			

5			
6			
7			

Recommendation 1. Communication between responsible clinicians when a patient on a CTO is transferred between services

7.42 This action was assessed as having a low potential impact in terms of changing behaviour and practice, and therefore would have limited effectiveness in reducing risk. The trust should consider how it assures itself that this communication between responsible clinicians ensures that such transfers are effective, and supports the service user's needs.

Recommendation 2. Ensuring CPA review form is completed to the trust standard

7.43 In terms of changing behaviour and practice, the actions associated with this recommendation would have a moderate impact. Not enough information was provided, such as audits of supervision or completed care plans, that would have provided evidence to support the implementation and impact of these actions. The trust should consider how the effectiveness and thoroughness of process changes implemented are scrutinised and monitored through its quality governance and assurance systems to support staff in their clinical work and provide benefits to service users.

Recommendation 3. Accuracy of risk assessment

7.44 The action associated with this recommendation relies on a mix of human and system interventions, which would have moderate impact in terms of changing behaviour and practice. Interviews held with staff indicated that they felt that the clinical risk management system frequently asked questions had helped to improve the standardisation of quality and recording of risk assessments. The trust did not however provide any evidence to support these views. The trust should consider how to assure itself that the new clinical risk management system frequently asked questions are supporting staff and ensuring that the quality and consistency in recording of risk assessments have improved.

Recommendation 4. Review of care plan at time of discharge from CTO

7.45 The action associated with this recommendation relies on human (such as reminders) rather than system intervention, and would have low impact in terms of changing behaviour. Although easy to implement, the effectiveness of the planned action in reducing risk is limited. The trust provided no evidence that care plans are

reviewed when a service user is being discharged from a CTO, or that the team is up to date with their care plan approach (CPA) training. The trust should consider how it monitors and scrutinises the implementation of these actions through its governance and assurance processes.

Recommendation 5. Consideration of wider support to support the case

7.46 The action associated with this recommendation relies solely on human rather than system intervention and would have low impact in terms of changing behaviours. The trust provided no evidence that staff had been reminded of the wider resources that were available to support complex cases. The trust should seek assurance that clinical staff have sufficient support to access a wider network of support to assist in complex cases. It should consider how it monitors and scrutinises the implementation of this action through its governance and assurance processes.

Recommendation 6. Clinical supervision

7.47 The investigation found that although staff received clinical and caseload supervision frequently, the system for recording it was not robust or accurate. Actions to improve this included a review of the supervision contract, a workshop, and a review of the quality of supervision. These actions are a mixture of human and system intervention and have moderate impact in terms of changing behaviour. The trust gave verbal confirmation that there were already standards in place for clinical staff to receive supervision (clinical supervision policy). It also confirmed that in 2020 a review cycle had been set up to assess the quality of supervision, and to ensure that the standards set out in the policy were being achieved. However, no concrete evidence of these actions was provided to the Facere Melius team. The trust should seek evidence to assure itself that the quality and frequency of supervision has improved and consider how this will continue to be monitored through its governance and assurance processes.

Recommendation 7. Medication changes sent to GP practice

7.48 The action associated with this recommendation would have moderate impact in terms of changing behaviour and practice. The action focused on the trust reporting the medication incident to the local Commissioning Support Unit through their safeguarding and risk management system (SIRMS). The local Commissioning Support Unit was to monitor progress of this action. This is beyond the scope of the trust to monitor, and no further work is needed, as the trust would not be able to control the implementation of this action.

Commentary

C19. The Serious Incident Framework (2015) recommends using the National Patient Safety Agency (NPSA) action plan using SMART principles: Specific, Measurable, Attainable, Relevant and Time-bound. The actions described in

the report and action plan do not take this approach. An example of this is the reference to sending reminders to a team of staff about the resources available to them. According to the trust's policy, the Serious Incident Review Panel is responsible for agreeing SMART actions, timeframes, and agreeing the evidence that will be required to validate their completion. The FM team has seen no evidence that this has happened.

C20. The recommendations and associated actions, when judged collectively, focus heavily on human rather than systems reliability as methods for producing change and improvement. Impact in terms of effectiveness of risk-reduction strategies is therefore limited.

C21. The trust has provided limited evidence to understand how the actions resulting from the case of MB have had a positive impact on service users and clinical staff. Evidence of such an impact could have included, for example, evidence of improving trends in patient satisfaction feedback, and the decrease of issues arising in complaints that relate to the findings and learning from this case. Other examples include results from clinical record audits, and demonstrating that the quality of care plans, risk assessments and medication records has improved. Staff feedback, supervision records, findings from peer reviews, and CQC inspections can also be used to show that the quality of service delivery has improved.

C22. Quality improvement methodology and clinical audit should be used to evidence improvements in clinical practice following the implementation of actions. The trust has not provided evidence of how it has monitored the implementation of actions arising from the recommendations of this internal investigation to assure itself that learning and changes or improvements in practice have taken place.

C23. The review team were unable to find evidence of effective information sharing between key agencies, specifically the police and health services. This would clearly impact on the ability of both to effectively assess the risk posed by MB and to implement an appropriate risk management plan.

Section 8: Clinical review

Review of MB's risk assessment and safety management

8.1 The trust uses clinical risk assessments to help assess the risks for their patients facing mental health problems. Risk assessments are part of a collection of tools produced by Imosphere (see references) to support staff in their evaluation of clinical

risk levels. Risk assessment includes consideration of the risk to the patient and their risk to others so that a proactive safety management plan can be considered.

8.2 The last formal clinical risk assessment was completed on 28 July 2018 by nursing staff from the crisis team. This was prompted by MB's CTO having been revoked and his subsequent recall to hospital. This decision was because he did not engage with mental health services and refused his depot medication as planned. The risk assessment did not include crisis, contingency and safety management plans. The assessment did not explore strengths and protective factors (see Glossary) in any depth and whilst there were symptoms indicative of risk noted, and early warning signs mentioned, there was no plan in place to reduce or manage these.

8.3 Clinicians assessed risk informally on an ad hoc basis when MB met with them for appointments, noting risks in the progress notes. The FM review team understands that the trust requires that clinical risk assessments are completed every six months, however, in this case there was no formal clinical risk assessment completed after 28 July 2018 (10 months prior to the incident). Had formal clinical risk assessments been completed, and with greater frequency, the more recent risks could have been consolidated and been more accessible to the teams working with MB. Clinical risk assessments should be used as a dynamic tool that is updated every time there is a significant change that could impact on the level of risk.

8.4 Although MB and clinicians caring for him considered his elderly family members as protective factors, there is no evidence provided by the investigation report that there was a solid foundation to support this assumption. If there had been, then the information arising from these sources could have usefully informed MB's assessment and treatment.

8.5 Home visits by clinical staff were ceased due to MB carrying an offensive weapon and his association with a known drug dealer. The subsequent safety plan appears to focus on protecting staff, and is cited in the investigation report as an example of good practice. The identified risks however to both MB and to others, including his thoughts and threats to kill, were not sufficiently considered in relation to the safeguarding of his immediate family and the public.

8.6 A genogram is a diagram illustrating a person's family members, how they are related, and their medical history. It is a way of recording and interpreting a patient's family's history so they can better understand the genetic, medical, social, psychological and cultural aspects of their family that might impact them. It allows the patient to see hereditary patterns of behaviour, especially those that they may want to stop like abuse, conflict, legal problems or addiction. Genograms have been found to help specifically in patients with substance misuse.

8.7 No evidence of a completed genogram was found in MB's clinical risk assessments, CORE assessments or progress notes. There is a facility for the inclusion of a genogram in the clinical risk assessment template.

Medication

8.8 A depot injection is a slow-release form of medication. The injection uses a liquid that releases the medication slowly, so it lasts a lot longer. Depot injections can be used for various types of drug, including as in this case, antipsychotics. A more assertive approach would have been appropriate when MB decided he no longer wished to have his depot injection because of the side effects he reported. Receiving depot injections was a condition of his CTO.

8.9 There was no robust medicines management care plan in place in order to manage the risk of non-compliance or adverse reaction to the depot.

Substance misuse and management

8.10 When the review team spoke with MB, he admitted to using crack cocaine daily and street nitrazepam in the period before the incident in order to help with the 'come down' from the crack cocaine. Nitrazepam is classified as a benzodiazepine and is a commonly abused recreational drug. Benzodiazepines are prescribed medically to treat anxiety. They are known to be habit forming and can cause addiction. Street benzodiazepines are used to come down off other illicit drugs used as stimulants, such as acid, cocaine, speed or ecstasy. Using a street version of nitrazepam increases the risks involved in drug abuse: there is no guarantee of their quality or if they are actually nitrazepam.

8.11 In an interview, MB's consultant psychiatrist stated he prescribed a small amount of temazepam (12 tablets per month) to try to minimise the harm from other street benzodiazepines and to discourage MB from using the same. MB's consultant psychiatrist refused to continue with the prescription, as MB was becoming increasingly threatening if this prescription was not increased, so MB commenced the process of looking for another responsible clinician.

8.12 MB's consultant psychiatrist confirmed in an interview with the FM team that MB was at the 'pre-contemplative' stage of his drug use (at this stage people are not thinking seriously about changing and are not interested in any kind of help). It could have been useful at this point to have delivered some brief interventions focused on motivation and exploring his ambivalence. There was no evidence that MB was given a dual diagnosis. Getting dual diagnosis treatment, rather than individual mental health or substance use disorder treatment, can enable patients to break negative patterns and learn positive coping skills in therapy to improve their mental health.

8.13 MB was also prescribed pregabalin for anxiety, which is a drug known to have a high street value with drug users. As those treating MB only had his word that he was taking his medication as prescribed, they would not have known if he sold it. Regular drug screening as set out in his CTO could have confirmed his level of compliance. The same can be said for the temazepam.

Care Programme Approach (CPA) and care plans

8.14 The term Care Programme Approach (CPA) describes the approach used in mental healthcare to assess, plan, review and coordinate the range of treatment, care and support needed for people in contact with services who have complex care needs. Individualised care plans are developed with patients using this approach, aimed at developing a plan that can deliver the optimum approach likely to be successful in addressing the challenges the patient faces as part of his mental health and substance misuse.

8.15 The care plans reviewed in this case were not strengths based. For example, there were no 'SMART' goals, and the plans were not recovery orientated. The CPA approach outlines *'The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasises: positive risk management; collaboration with the service user and others involved in care; the importance of recognising and building on the service user's strengths; and the organisation's role in risk management alongside the individual practitioner's'* [Refocusing the Care Programme Approach, March 2008].

8.16 The ongoing involvement of families/carers is fundamental to producing effective care plans. Services should regularly listen to a patient's views and those involved in their care and support so that care plans can respond to changes in their needs and any fluctuations in levels of risk. The review team did not see evidence of collaboration with MB's family in the development of his care plans. No evidence was found that MB's relatives had been offered an assessment of their needs as carers.

Community Treatment Order (CTO)

8.17 A community treatment order (CTO) is an order made by a patient's responsible clinician (RC) under the Mental Health Act 1983 to give them supervised treatment in the community. This means they can be treated in the community for a mental health problem, as a less restrictive alternative to being detained in hospital. They are designed to prevent repeated relapse that leads to frequent readmission that makes their lives very difficult. They are generally made for a maximum of six months. A responsible clinician can however return a patient to hospital and give them immediate treatment if necessary.

8.18 A responsible clinician can only make a CTO if someone is in hospital, detained under certain sections of the Mental Health Act:

- section 3
- section 37 hospital order
- unrestricted transfer direction under section 47

A CTO cannot be used if a patient is on a Mental Health Act section 2, 4, 5 or has been discharged from their section.

8.19 A CTO can be considered under the following patient circumstances:

- they are suffering from a mental disorder that needs treatment
- medical treatment is needed for their health or safety, or for the protection of others
- suitable treatment is available in the community.

8.20 The CTO will come with certain conditions that patients must follow as a legal requirement. Sometimes, if a patient does not follow the conditions or becomes unwell, the responsible clinician can recall them for treatment. Whilst in the community, the patient will have a specialist team responsible for their care and a named care coordinator will provide regular contact.

8.21 MB was discharged from hospital on a CTO three times: October 2017, June 2018 and August 2018.

8.22 The conditions attached to the CTOs were:

- adhere to treatment plans in the community
- attend appointments
- accept prescribed medication and comply with urine tests
- avoid illicit drugs.

8.23 MB's patient record shows that clinical staff believed that once in the community there was a risk that MB would not comply with taking his medication and would not attend appointments. On discharging him from his CTO, his responsible clinician (RC) recorded in his clinical notes that staff would be fully reliant on MB to be compliant with his antipsychotic medication. The RC also referenced the need to apply the least restrictive practice in MB's case by way of justifying his decision to discharge him from hospital.

8.24 When the CTO was removed in February 2019, this risk was realised, and his non-attendance at appointments with his care coordinator and RC increased. For example, he did not attend his monthly appointment with his RC in March 2019 and it was recorded that at this point, a decision was taken to cease home visits with effect from 23 March due to MB's risky behaviour. Although staff were aware of this pattern of increasing risk, they decided to reduce the frequency of his appointments.

8.25 Clinical notes record MB reporting that he was 'hearing voices' at this time and it appeared his level of paranoia had increased. MB had reverted to oral antipsychotic medication as his depot injection had ceased due to his non-compliance. Review of clinical notes show that MB was known to carry weapons when paranoid and his non-compliance with medication put him at risk of a relapse. According to clinical records, MB's interaction with services continued to be erratic after his CTO discharge. He did not attend arranged appointments but he would proactively contact the crisis team for help. MB's records show that he continued to express suicidal thoughts at this time, but with no plans outlined. His contact with services often involved requests for an increase in his temazepam prescription. On 5 April 2019, MB's records show that there was a plan to discuss his engagement with services at a pathway or MDT meeting. The review did not find any evidence that this was done before the incident occurred.

Commentary

C24. Research has shown that there are many short and long-term benefits of engaging families in the care of patients with mental illness. Family engagement has been found to lead to better outcomes, such as fewer relapses, longer duration between relapses, reduced hospital admissions, shorter inpatient stays, and improved compliance with medication and treatment plans. Families can also help with early detection of the warning signs of relapse, and help patients access services in times of crisis. Family engagement has found to be beneficial not only to patients, but can also ease the burden on family members as carers. Family members should be offered an assessment of their needs as carers.

C25. MB stated his elderly family members with whom he lived were involved in his care to some extent and he believed they had been involved in his care plans. No evidence of them being offered an assessment of their needs or risks as carers was found. It was unfortunate that another family member who was heavily involved in his care during his spell as an in-patient, was not involved in his care in the community. This was a missed opportunity to maintain consistent involvement of MB's family in his care.

C26. The triangle of care (see glossary and references) aims to achieve better collaboration and partnership with carers in the service user and carer's journey through mental health services. It is noted in national guidance that

> *'Canvassing the views of carers at such times [periods of crisis] may be key to ensuring that any risk factors they are aware of are properly evaluated and acted upon. It has been a feature of a number of inquiries into serious incidents that failure to communicate with and listen to carers and families has been a significant contributory factor'.* [Carers' Trust, 2013]

C27. Clinical staff working with mental health patients assess risk continuously. This is reflected in the progress notes within the patient record. The quality of the risk assessment recorded in MB's case however did not meet the expected standard and management plans were not reflecting his current presenting risks; his last plan was dated April 2018. A robust assessment of MB's risk, including potential mitigations, would have included the following:

- Clinicians should make it clear when updating records that they are aware of the patient's last clinical risk assessment and risk management plan
- Clinical risk assessments should be reviewed in line with the trust's requirement of a minimum of six months, or when a significant change takes place, which was not done for MB.
- Formal risk assessments should be updated when significant changes occur that could impact on the level of risk for the patient or others, usually as part of CPA or lead professional review. When staff review risk assessments, they should consider the need for crisis, contingency and safety management plans. This was not evident in the case of MB.
- Completion of the genogram section of the clinical risk assessments could have provided MB with greater insight into how his family background might have affected him. The potential impact of this information could have been used by staff to help MB manage his inherent risks.
- Risk assessments should thoroughly explore the strengths and protective factors surrounding a patient, such as the benefits from consistent involvement of a patient's family for the duration of his treatment. The support provided by MB's family member whilst an inpatient was not pursued by staff after he was discharged on a CTO. This individual may have had a positive impact on some of MB's behaviours, particularly compliance with his depot injections.
- Where increased risks are noted, such as the carrying of weapons or other threatening behaviour, a risk assessment should be updated to consider all associated risks, including the risk to the patient, their family members with whom they have contact, staff, and the wider public. Had this happened in MB's case, a risk mitigation or risk management approach should have been taken including, for example, reporting concerns to third parties such as the police and the local authority.

C28. There was no formal multi-disciplinary team meeting before discharging MB from his CTO. Holding a formal CPA meeting with other members from the multidisciplinary team, his GP and family members, would have been good practice to consider the most effective support and treatment mechanisms that could be put in place for MB.

C29. A robust medicines' management care plan should have been in place to manage the risk of MB's non-compliance or reaction to the depot under the

community treatment order (CTO). The prescribed medicines regime was important in the management of MB's psychosis and to reduce his risk of misusing illegal drugs. Refusal of his depot meant that he was prescribed oral antipsychotics which have a high street value. As previously stated, MB was known to sell prescription drugs and therefore it may have been prudent to have reviewed his use of temazepam and pregabalin for alternatives in light of this.

C30. Clinical staff knew that MB used illicit drugs. MB admitted to the review team he was using crack cocaine daily and street nitrazepam before the incident. There were however no conditions attached to his CTO that may have helped MB address his drug taking, aside from drug screens which he adamantly refused to participate in. MB would deny any illicit drug taking and MB's consultant and care co-ordinator considered that it was difficult to discuss a joint assessment with substance misuse services with him, as he had refused previous offers of intervention and support. Patients with a dual diagnosis often find it difficult to engage with services; they drop out and miss appointments and tend to have difficulty adhering to treatment plans. A more assertive approach, i.e. a joint assessment could have helped with engagement and motivation in this case, helping MB to see the benefits of treatment, this was a missed opportunity. MB told the FM review team that, with the benefit of hindsight, discussions with the dual diagnosis team may have helped him. MB confirmed during his interview that he felt safer on his CTO as he was seen monthly.

Section 9: Systems, safeguarding, governance and compliance

9.1 The FM review team referred to relevant NICE guidance, local and national policies relating to managing risk, the care programme approach, crisis treatment, and others listed in the references section (see references: section 14). They also considered the NHS England Serious Incident Framework – supporting learning to prevent recurrence (2015) as part of its evaluation of the trust's incident investigation.

Safeguarding and family dynamics

9.2 The review team met with MB's family to elicit their view on the quality of the care he received from the trust. MB was interviewed via a prison video link.

9.3 Both the family and MB felt that he was 'let down' by mental health services, as they considered that there were opportunities for agencies to act when they had escalated concerns and requests for MB to be sectioned. When he became unwell previously (2015, 2017 and 2018), he had contacted services such as the Crisis Resolution Home Treatment (CRHT) team who would arrange his admission into hospital. MB confirmed that the last time he called on 8 May 2019, they would not

agree to admit him. MB's recollection may be with the benefit of hindsight, recognising now that his condition was deteriorating and that an admission might have prevented the murder. He had previously self-referred to the crisis team and been admitted for treatment on a section when he felt his psychosis was worsening.

9.4 MB described being close to his elderly family members with whom he resided and he understood they were involved in his care planning. He told the review team that he believed it was approximately 10 years earlier that he started feeling unwell with regard to his mental health. He added that maybe he was 'not right' as a child.

9.5 MB said that he was not happy with the service he received from CMHT. As previously explained, he felt that being on the CTO helped as he then saw people once a month. He went on to say that he became worried when the CTO stopped, and he became more paranoid at this point.

9.6 The FM review team has not received information that any safeguarding referrals were made to the local authority regarding either MB or his family. It would have been an expectation that a safeguarding referral was made for his immediate family members with whom he was living, at the time when MB attacked another family member, and again in March 2019 when it was decided that home visits by staff would be withdrawn due to the perceived risks from MB and his associates. This is seen as a missed opportunity to provide appropriate support to his family and consider the risks they faced as a result of MB's lifestyle.

Inter-agency working

9.7 MB had a significant history of violent behaviour, albeit that he had not been formally prosecuted with respect to the allegations. This history included seven domestic abuse reports. He was not prosecuted for the most serious allegation regarding the stabbing of a family member who named MB as the offender but would not support a police prosecution.

9.8 Whilst the chronology, developed by FM does identify some limited sharing of information between agencies, primarily the NHS and the police, this was on an ad-hoc basis. The review was unable to find any evidence of formal multi-agency information sharing, risk assessment or risk management planning relating to MB.

9.9 Considering his forensic history, MB would have qualified as a serial domestic abuse offender. This is in line with College of Policing guidance (see glossary and references). He could have been considered for a multi-agency risk assessment conference (MARAC, see glossary and references) referral as a means of ensuring more effective, cross-agency offender management.

9.10 MB would probably not have qualified for MAPPA (multi-agency public protection arrangements) as he does not appear to have had a qualifying conviction. He could however have been considered as a potentially dangerous person (PDP) as defined by the College of Policing guidance. This would require a formal meeting of appropriate agencies, ensuring that all relevant information was shared to support the risk assessment process and the development of an effective, cross-agency, risk management plan.

Commentary:

C31. The family and MB gave the review team their thoughts on the mental health service and the feelings of being 'let down'. As previously explained, MB confirmed he was using illicit drugs and with the benefit of hindsight he felt the support of the substance misuse team may have been of assistance to him. MB's family was not involved in his care management or assessment of risk when he was in the community. This was a missed opportunity to place MB on an effective care and treatment pathway.

C32. Trust staff did not consider the safeguarding needs of MB's elderly family members with whom he lived when they assessed that his pattern of risk had increased. It would have been appropriate for trust staff to have made a vulnerable adult safeguarding referral to the local authority.

C33. The review team was told that the trust does not routinely engage with external agencies, specifically the local police force, to share information, and discuss risk assessment and risk management plans for service users. The trust explained, however, that staff would usually engage with external agencies to share information when clinically indicated, through multi-agency meetings.

C34. The lack of engagement by the trust with the police-led MARAC and PDP processes is considered to be a missed opportunity. MB's significant violent behaviour and risk of harm to others could have been properly understood and considered by all those involved in his risk assessment and care management. A cross-agency approach such as this could have resulted in a much more robust risk management plan being put into place, specifically around MB's detention status and consideration of a CTO, medicines management plan and local authority safeguarding team's risk assessment.

Investigation and learning from incidents

9.11 The review considered the trust's Incident Policy (Including the management of Serious Incidents), 2016 in place at the time of the investigation. The trust policy is supported by a series of what are termed: Incident Policy Practice Guidance Notes. Relevant to this review are:

- Investigation of Incidents – V02, Issue 4 – January 2012
- Learning Lessons from Incidents and Near Misses – V04, Issue 3 – April 2019.

9.12 Providing practice guidance notes for staff to support them in the application of trust policy is seen as good practice. Providing information in this way can help busy members of staff focus on the practical elements of delivering an investigation, and reduce the risk of misinterpretation of more lengthy policy documents.

9.13 The policy states that investigations are communicated to the trust board of directors via monthly reports relating to safer care, which outline the activity for the last period, acknowledging the systems and processes in place within the trust, and an update around increases or decreases to specific serious incident activity over the last quarter. The policy contains the definition of homicide by a person in receipt of mental health care within the recent past, in line with the 2015 serious incident framework. It does not however define the three levels of investigation as described in the framework. This should include a definition of when an independent or externally led investigation might be considered.

9.14 The review team found some inconsistency between the trust's incident policy and its guidance documents regarding the timeframes for investigating and reporting on serious incidents, which could lead to misunderstanding. The trust's policy does not include reference to timeframes for the completion of serious incident investigations.

9.15 The Learning Lessons from Incidents and Near Misses guidance note (2019) states:

'*Within 60 working days of serious incidents being investigated they are presented to the serious incident panel and any learning, reflection is shared with the Locality Care Group Directors, senior clinicians and the service involved. The Associate Director will action any improvements and share with the team or wider within Clinical Services through their established learning systems.*'

9.16 The Investigation of Incidents guidance note (2012) used by the investigating officer, and referenced in the report, states however that a final draft of the investigation report is to be submitted for quality check within 25 working days, with the final version signed off at 30 working days. According to this note, all actions should be completed within 60 working days, which is contrary to the national framework, 2015.

It states the Associate Director will action any improvements and share with the team or wider within clinical services through their established learning systems.

9.17 The Learning Lessons from Incidents and Near Misses guidance note (2019) states that it is designed to support an effective organisational learning culture through a robust reporting and investigating process that supports staff. It captures the processes in place to aid this at all levels within the trust. It provides a visual representation that explains the processes for sharing, reporting and learning activity associated with incidents and complaints. It includes reporting to the board of directors as part of the cycle of Board Safety Reports.

Commentary:

C35. The use of supporting practice guidance notes is seen as good practice in terms of supporting staff to enact trust policy in a practical manner, and reducing the risk of it being misinterpreted. The trust should ensure however that its policy and supporting practice guidance notes are aligned, consistent, reflect up-to-date national guidance, and include the following:

- Clear instructions for the reporting and investigation of homicides by a person in receipt of mental health care within the recent past.
- Consistent timeframes for the conclusion of investigations following serious incidents i.e., currently 60 working days as set out in the 2015 serious incident framework.
- Explanation of the three levels of serious incident investigation, and the criteria to be used in selecting the level most appropriate.
- A clear definition of when an independent or externally led investigation might be considered.
- How it plans to utilise external contractors to undertake serious incident investigations, and what their status is in terms of independence.
- Ensure that all those undertaking investigations have access to clear, up to date and consistent guidance.

Section 10: Conclusion

10.1 This review has examined the key lines of enquiry required from Facere Melius' terms of reference which can be summarised as follows:

- conduct a desktop review of the trust's internal investigation
- check the investigation's lines of enquiry were robustly considered and explored
- formulate recommendations that are sustainable and lead to measurable improvements

- identify learning opportunities and what is expected to change as a result

10.2 This report explores each of these lines of enquiry, analysing the review findings and capturing opportunities for learning and improvement throughout in its commentary at the conclusion of each section. In conclusion, this section summarises those findings and learning points. Sustainable and measurable recommendations will be developed in consultation with key stakeholders.

10.3 The purpose of a good serious incident investigation is to enable an organisation to understand where it has gaps or weaknesses within its delivery of services so that they can be rectified. It is important that trusts update their operational approach to serious incident investigation when the national approach changes.

10.4 The review found a number of issues with the approach the trust had taken to investigate the homicide. For example, how the terms of reference were developed and the approvals process was unclear. The review noted that families and key stakeholders such as MB's GP, the police, and commissioners did not contribute to this process.

10.5 The investigation methodology applied in this case did not provide the evidence to be expected from a serious incident investigation and that would have been present had a root cause analysis and human factors approach been effectively applied. The absence of this evidence reduces confidence in the authenticity of the investigation findings and their associated recommendations.

10.6 The recommendations and actions from the trust's investigation lacked clarity and did not address some of the investigation findings. The potential impact of actions was assessed as being low. Recommendations were not developed in collaboration with key stakeholders and actions were not SMART. It was unclear how the completion of actions would be validated.

10.7 Clinical review showed that the quality of risk assessments and contingency plans for MB did not reflect his presenting risks, and were not updated regularly. The increased risk to MB, his family and others, such as when he was known to be carrying weapons and exhibiting threatening behaviour, did not trigger robust safety management plans. Medications management plans were not sufficiently purposeful in addressing his non-compliance and considering engaging the dual-diagnosis team.

10.8 The absence of appropriate information sharing within the trust's multi-disciplinary teams was concerning. For example, holding an MDT meeting prior to removing MB's CTO in 2019 may have had a positive impact on decision-making at that point.

10.9 The review identified that family and carer engagement and their positive protective impact on MB were not sufficiently explored. The potential risks to close relatives were not properly considered or reported to the local authority.

10.10 The objective of strengthening the trust's quality assurance is to generate improvement in all of these areas. Learning from this case demonstrates that the assessment of patients' risk to self and others, and patterns of violent behaviour, need to be comprehensively understood and well documented. The wider inter-agency sharing of information across public services such as the prison service, probation, social care, housing, mental health and NHS physical healthcare will support the development of well-informed and holistic risk assessments and ensure risk management can be enacted across all service user touch points with public services.

Section 11: Recommendations

The commissioners of this investigation, NHS England, will ensure that each of the individual and statutory agencies involved in the care and treatment of MB will develop (a) robust action plan(s) to address the recommendations outlined below.

Clinical risk management

R1 With the transition from Care Programme Approach (CPA) to the Community Mental Health Framework, the trust must ensure that principles are effectively embedded within the organisation and staff supported by appropriate training. The trust must ensure an agreed cycle of regular quality monitoring and supervision arrangements so that care planning, risk assessments and safety management plans are routinely assessed against an agreed minimum standard.

Clinical practice (waiting lists and interim care plans)

R2 The trust to ensure Responsible Clinicians (RCs), responsibly exercise their power under the Mental Health Act when discharging a patient from their CTO because the criteria for making it no longer apply. A formal multi-disciplinary team (MDT) meeting should be held with colleagues to discuss the patient and agree an appropriate care plan. The RC and the MDT should consider the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm to themselves and the general need to protect others. Every effort should be made to involve close family members/carers in ongoing care planning.

Safeguarding

R3 The trust should ensure that all staff know how to identify and report safeguarding concerns when a patient has a forensic history and a potential for violence. This is so that the risks to family/carers are properly considered and acted upon to help keep them safe.

Medicines management

R4 The trust should ensure that staff preparing medicines management care plans take into account the risk of non-compliance where this is indicated. Where drug dependency is a factor alongside a diagnosed mental health condition, a co-occurring mental health and substance misuse assessment should be conducted.

Cross-agency information sharing

R5 The trust should ensure robust application of existing mechanisms for sharing relevant information with known system partners. The cross-agency sharing of information about service users with severe mental health conditions, particularly when combined with drug dependency and a history of violent and criminal behaviour, can lead to better management of the risks of harm to themselves and/or others.

System-wide MOU / Post incident Information sharing and cross agency working

R6 A system-wide information sharing agreement or memorandum of understanding to be put in place, so that all agencies involved in the care, treatment or management of a service user are given the opportunity to contribute to a system wide investigation, and investigators have access to all relevant records.

Quality governance framework

R7 The trust should consider developing a quality governance framework so that actions and learning arising from serious incident and other adverse events result in measurable quality improvements. Quality governance frameworks capture how patient safety and patient experience intelligence from sources such as: serious incident investigation, incident themes and trends, complaints, inquests, claims and quality improvement mechanisms including clinical audit connect with the wider trust governance framework.

Section 12: Appendices

- Appendix one – Assurance review terms of reference (ToR)
- Appendix two - Facere Melius quality and assurance frameworks
- Appendix three - Facere Melius quality framework - investigation report
- Appendix four - Facere Melius assurance framework - action plan

Appendix one – Terms of Reference

Terms of Reference for Independent Review under NHS England's Serious Incident Framework 2015

The Terms of Reference for an independent review have been set by NHS England and NHS Improvement regional team. The Terms of Reference have been developed in collaboration with the investigative supplier and family members.

Purpose of the Review

To undertake a desktop review of the internal investigation into the care and treatment of Mr MB undertaken by 'the Trust', to determine whether the internal investigation lines of enquiry were robustly considered and explored, highlighting any areas requiring further examination.

Based on review findings, formulate recommendations which would lead to sustainable and measurable improvements.

To identify and communicate any early learning opportunities determined throughout review activities and what is expected to change as a result.

Involvement of the affected family members and the perpetrator

In collaboration with NHS England, ensure that all affected family members are informed of the review, the review process and are offered the opportunity to contribute including developing the terms of reference and agree how the updates on review progress will be communicated including timescales and format.

Involve affected family members throughout the review as fully as is considered appropriate, in liaison with Victim Support and/or other support or advocacy organisations.

Share the report in an agreed format with affected families, seek their comments and ensure that appropriate support is in place ahead of publication.

Offer Mr MB a minimum of two meetings, one to explain and contribute to the review process and the second to receive the report findings.

Scope of the Independent Review

To undertake a critical analysis of the internal investigation's approach and key lines of enquiry, to determine whether these were appropriate at that time, adequately considered and explored, highlighting any areas requiring further investigation.

It is NHS England's expectation that this will incorporate the consideration of the following:

- Review of the clinical records, to determine the relevant historical context, identification the significant periods of care delivered of relevance to the incident which occurred.
- Interviews with key personnel where necessary, to provide additional supporting information.

- Development of a comprehensive chronology of events, against which the internal investigation's findings will be considered and assessed.

- Following the incident, consider and assess the Trust's response, to identify and implement any immediate learning.

- As part of the desk top review, determine and assess the progress made by the Trust in implementing the learning points relating to the additional findings referenced within the internal investigation commenting on whether there is sufficient evidence to demonstrate implementation and effectiveness.

- With a focus on learning, identification of any gaps, deficiencies or omissions in care and treatment of the service user not adequately addressed within the investigation undertaken by the Trust.

- Review the adequacy of risk assessments and risk management including risk assessment during periods of behavioural change or change in personal circumstances and the risk posed to others specifically in relation to risk assessment/risk of violence and how this information was shared.

- Exploration of whether Mr MB's family had alerted professionals to any mental health concerns, or vulnerabilities and if so, how was this acted upon.

- Examine the effectiveness of the service user's care plans and the effectiveness of CPA reviews.

- Determine whether Mr MB's informal and primary carers were recognised and were able to influence care planning or offered an assessment of their needs as a carer.

- Review the appropriateness of the treatment of the service user in the light of identified health and social care needs, identifying both areas of good practice and areas of concern.

- Assessment of compliance with local policies, national guidance and statutory obligations including safeguarding.

- Consider any issues raised in relation to safeguarding (adults) and determine if these were adequately assessed and acted upon.

- Based on overall review findings, constructively review any gaps in inter-agency working and identify opportunities for improvement including making recommendations for expected standards and modes of communication between organisations.

- Identify any notable areas of good practice and further opportunities for learning determined throughout the review activities and outline what is expected to change as a result.

Deliverables

Based on review findings make organisational or service specific recommendations which are outcome focused with a priority rating and expected timescale for completion.

Provide a written report to NHS England that includes findings and recommendations for further action where necessary. The report should follow both the NHS England style and accessible information standards guide.

Provide a concise case summary clearly indicating learning points and opportunities, to enable wider sharing of learning.

Provide an opportunity for the families to receive supported feedback related to findings.

Provide NHS England with a monthly update on progress, template to be provided by NHS England, detailing actions taken, actions planned, family contact and any barriers to progressing the investigation.

Attend an action planning meeting to deliver the key findings and any recommendations to the Trust and Stakeholders.

Where recommendations are made, conduct an evidenced based Assurance Review within 6-12 months following publication of the report to assess implementation and monitoring of associated action plans.

Provide a short-written report to NHS England outlining the findings of the Assurance Review.

Appendix two – Facere Melius Quality and Assurance Frameworks

Facere Melius Quality Framework

This framework is used to assess and RAG rate (Red, Amber, Green) the trust's internal investigation report. The framework guides the reviewer to consider key points around the terms of reference, methodologies, findings and recommendations.

Facere Melius Assurance Framework

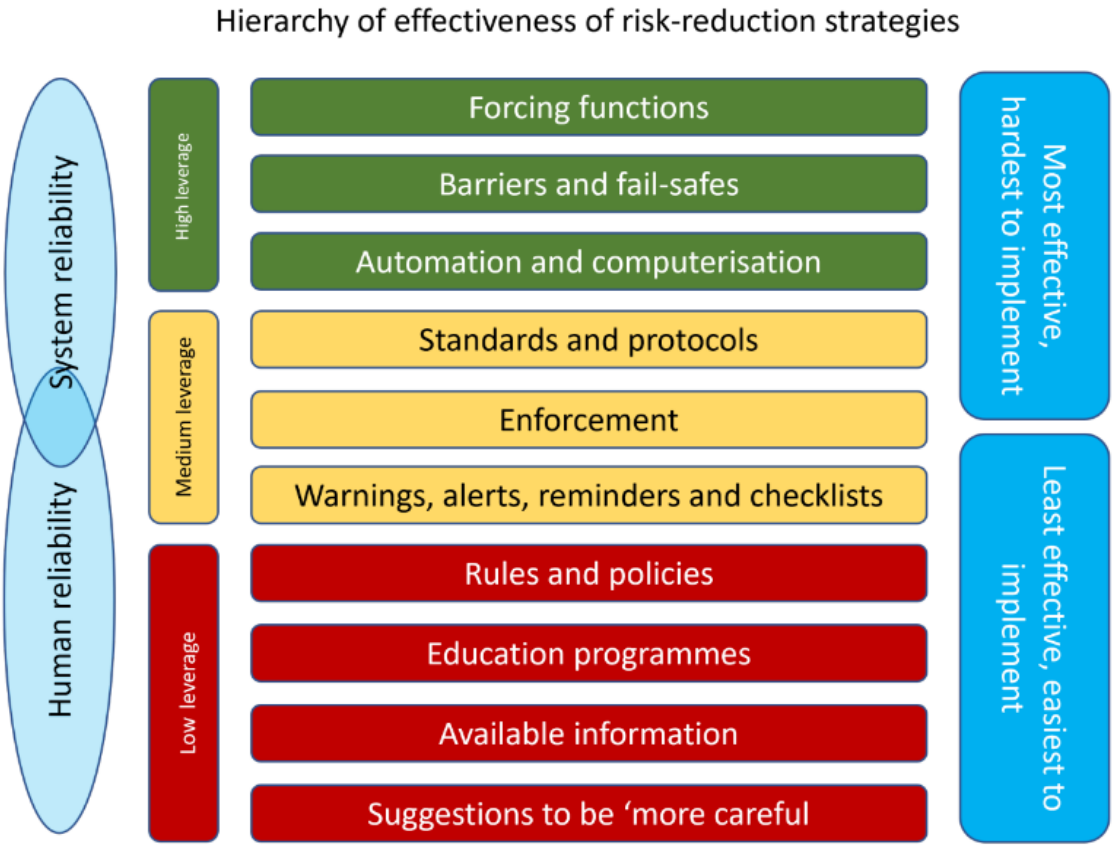
The FM assurance framework is used to review the quality and robustness of the action plan developed, focussing on establishing the adequacy of the findings, recommendations and the implementation of the action plan.

- Effectiveness of intervention
- Maturity of implementation
- Quality of assurance

This framework is based on the recognised international models of assurance

- Hierarchy of Effectiveness
- 4 Lines of Defence model

Effectiveness of Intervention	Maturity of implementation	Quality of assurance
Suggestions to be 'more careful'	No progress	No assurance
Available information	Basic level	Self control
Education programmes	Early progress	Management control
Rules and policies	Firm progress	Internal self-assessment, audit or review
Warnings, alerts, reminders and checklists	Results being achieved	Internal independent control
Enforcement	Maturity	Internal audit
Standards and protocols	Exemplar	External independent audit
Automation and computerisation		
Barriers and fail-safes		
Forcing functions		



[Adapted from the Institute for safe medication practices June 2020]

Appendix three – Facere Melius Quality Assurance Framework (Investigation report)

Quality Assurance Framework– investigation report

Review of internal trust investigation report

Terms of reference (ToR)	Rating	Narrative
Do they:		
• include time frames of treatment and care to be considered?	Amber	The terms of reference provided in the investigation report set out the period that the investigation was to cover - from the service user's first contact with the trust (2012) until the date of the homicide (2019). The investigation was to be undertaken in accordance with the trust's incident policy, with no specific date parameters. The level of investigation was not stated in the terms of reference (ToR); who drafted or approved the ToR was also not stated. The ToR included development of a chronology of the service user's care and treatment, but this was not included in the investigation report.
• list out all the stakeholders?	Amber	The ToRs did not include a list of stakeholders who had been involved with the service user but stated that views of family members and significant others should be sought.
• state to identify missed opportunities and identify care or treatment issues?	Amber	The ToRs state: 'identify care or service delivery issues, along with factors which could have contributed to the incident', and 'identify key issues, lessons and recommendations for the trust with a view to improving the care provided to future patients'. The wording could be more specific, in line with the national guidance for investigating serious incidents in place at the time.

• analyse if policies, procedures, guidelines (local and national) have been applied?	Green	The ToRs state the intention to review and assess compliance with local policies, national guidance and relevant statutory obligations. They also refer to standards established by professional regulators, including the General Medical Council (GMC), Nursing & Midwifery Council (NMC), and Health Care Professionals Council (HCPC)
• include details of the governance process for the report?	Red	The ToRs do not refer to any governance process or monitoring for the completed investigation report, or how it will be quality reviewed, approved and learning shared. The report was reviewed by the head of clinical risk, and by an associate director from the trust. The incident policy does not include a governance process for the monitoring, scrutiny and assurance of investigation reports, although within the policy is a list of responsibilities which includes the groups for sharing and monitoring.
• describe how the report will be shared with the family?	Red	The ToRs do not include information about how the investigation report or findings will be shared with the family. The trust's duty of candour policy: requires that within 14 days of the investigation being completed, the trust should write to a family or service user involved in an incident where an investigation has taken place, giving an apology (when appropriate) and details of events.
Have they been co-produced with		
• the family?	Red	No. The family were not contacted after an initial contact telephone call. This omission contravenes the trust's own policies, such as the incident policy, the being open policy, and NHS England's Serious Incident Framework 2015.

• the commissioners of the service?	Red	No. As this was classed as a serious incident, the commissioners of the services should have been involved in drafting the ToR, as they would have been responsible for monitoring implementation of the recommendations and actions, and any learning arising from the investigation.
• key stakeholders?	Red	The ToRs do not state if they were constructed in collaboration with any other stakeholders.
Report Authors	**Rating**	**Narrative**
• Do the authors have the right qualifications?	Red	The report does not state any information or biography of either of the report authors, therefore it is not possible to understand what their qualifications were. NHS Serious Incident Framework 2015 states that investigating teams should have relevant skills and competencies. The Facere Melius team were told, however, that the lead investigator was experienced in conducting investigations, had expertise in the use of root cause analysis methodology, and had a background in mental health practice.
• Have the authors been trained in investigation techniques?	Red	The report does not give information as to the investigators training. NHS Serious Incident Framework 2015 states for investigating team to have relevant skills and competencies. See previous comment.
• Have conflicts of interest been considered or registered?	Red	There is no mention in the report of any conflicts registered by the investigators.
• Do they have the right clinical experience required to make the judgements required?	Red	The report does not state the clinical experience of the investigators. NHS Serious Incident Framework 2015 states for investigating teams to have relevant skills and competencies. See previous comments.

Methodology	Rating	Narrative
Do they:		
• consider a full chronology of events from all stakeholders?	Amber	The ToRs are specific in stating the need to compile a chronology of events. The trusts report has a tabular timeline, giving a brief outline of events from 2012 of the care given from the trust to the service user, but this is not a full chronology.
• give due consideration to stakeholders who have not engaged?	Amber	The ToRs do not give the investigators the guidance or lead to access information from other stakeholders, for example, police and safeguarding.
• the tools and techniques that have been used during the investigation?	Amber	The report gives a list of evidence and information gathered, and lists the contributory factors framework applied to the investigation. It does not state whether a specific method was used, for example fishbone diagram. The report does describe some of the tools/techniques used for the investigation: • interviews • reviewing clinical records • investigation review meetings • GP report review There is however no explicit reference to the following: • evidence gathering • service mapping • using standard root cause analysis tools and techniques such as fishbone diagram analysis to identify service and care delivery problems, lapses, acts and omissions in care, tools to analyse contributory factors/root causes and fundamental issues

• engage with the families of both victim and perpetrator?	Red	The family of both victim and perpetrator were not contacted to engage with the investigation process. CQC regulation 20: Duty of Candour states that family/carers of both victim and perpetrators should be offered the opportunity to engage in the investigation process. NHS England Serious Incident Framework 2015 requires investigating teams to ensure that families/carers/patients/service users should be involved.
Findings	**Rating**	**Narrative**
Do the findings:		
• identify any contributory or human factors and missed opportunities?	Amber	The trust report identifies a number of contributory factors/systems and human factors with the care and treatment of the service user; however, these were not explored in any depth. For example, the risk profile on the clinical risk management system was said in the report not to be updated following each assessment, but was copy and pasted from previous entries, and did not reflect MB's current risk issues. This was found to be inaccurate. Management plans were not reflecting his current risks; the last plan was dated April 2018. Although the above points were identified, there was no analysis or description of contributory or human factors in the report. An after-action review (AAR) meeting that was held and concluded that a multi-disciplinary approach would have been beneficial in formulating a plan for a complex patient.
• Identify governance issues?	Amber	The report states there are a number of additional findings that predominantly relate to general recording in the clinical notes, updating assessments, management plans, and not following trust policy. There is no mention of monitoring of systems and processes within the trust, and no indication of audit plans.

Recommendations and the report	Rating	Narrative
Do the recommendations:		
• align to the findings?	Amber	The report makes no recommendations based on significant findings. It does state that additional learning was noted, and this forms the basis of seven recommendations and actions arising from them. There are other areas of learning that could have been included as recommendations or additional learning: • recording in electronic notes did not reflect the change in medication • risk management plan had not been updated since 2018 • 'getting to know you' section in the electronic clinical records did not indicate that any support had been offered to family members with whom the service user was living • multi-disciplinary discussion would have benefited this complex case, which was identified at the trust after action review (AAR) • Forensic services – the AAR staff identified a gap between forensic services and community teams when service users are not under probation The recommendations include actions with details of what requirements are needed to fulfil them. On a review of the implementation of the action plan it will be highlighted if all of their findings were taken into consideration.

• have high impact and proportionate actions?	Amber	Most of the recommendations were assessed by the Facere Melius team as likely to provide low to moderate impact. The actions developed in response to the seven recommendations were examined using the Hierarchy of Effectiveness of Risk Reduction Strategies tool (ref). Findings from this assessed four actions as having low impact (1, 4, 5 & 6), and two (2 & 3) moderate impact. One recommendation was not assessed as it is beyond the trust's remit to control the outcome. For example: Recommendation 4. The care plan was not reviewed at time of discharge from CTO. Action: Process to be reviewed and a reminder to be sent out to the team. To ensure that all members of the team have undertaken the CPA training. Using the framework, the following was concluded: 1. The action does not clarify precisely what process is to be reviewed, how it will be undertaken, and by whom. 2. The action of sending a reminder to the team is likely to have low leverage in terms of reducing the risk of recurrence, and whilst easy to implement, it relies on human rather than system reliability which reduces the likelihood of it being effective. 3. The action does not clarify what measures will be taken to ensure that all members of the team have undertaken the CPA training.

		4. None of the activities described include how the completion, outcome and impact of the actions will be measured or monitored. The 2015 Serious Incident Framework guidance to providers of NHS-funded care (paragraph 3.1) says: Investigations follow a systems-based approach to ensure any issues/problems with care delivery are fully understood from a human and systems factors perspective and that the 'root causes' are identified (where it is possible to do so) in order to produce focused recommendations that result in SMART (specific, measurable, attainable, relevant, time-bound) actions and learning to prevent recurrence.
• where appropriate, consider local and national changes from both a commissioner and provider perspective?	Red	The report and recommendations do not consider the impact of the incident and investigation on local or national policy. This should be explored further to ensure the learning from this incident is disseminated system-wide.
• describe the desired impact?	Red	The seven recommendations with actions arising give cursory description of their desired impact, and not in a way that could be effectively measured, monitored, or provided assurance of implementation.
• Have the recommendations been co-produced with the target audience?	Red	There is no evidence to suggest that anyone other than the report author has contributed to the recommendations.
• Does the report describe how learning will be shared and how the impact will be assessed?	Red	The report does not state how learning will be understood and embedded into clinical practice. It does not explain how this will be achieved, or how it will be assessed. There is no mention of methods of future monitoring to assess the impact of the changes arising from the actions implemented.

Appendix four – Facere Melius Assurance Framework (Action plans)

Assurance Framework – Action Plan

Investigation report

Recommendation 1	Following review of the transfer process it was identified that a discussion between the responsible clinicians (RCs) had not taken place. On this occasion it did not happen; however, it was noted there is a process in place. **Action:** To ensure RC-to-RC discussion when a patient on a CTO is transferred between services. This was discussed at the Adult Services Interface meeting and the Group CBU Job Planning meeting. Staff to be reminded of this process.		
	RAG rating	Narrative	Evidence submitted
Effectiveness of intervention	Suggestions to 'be more careful'	As this action relies on human rather than a system intervention to implement this will then have a low impact. This type of risk-reduction strategy has been found to have low impact in terms of changing behaviours and practice. It is easy to implement, but its effectiveness in reducing risk is likely to be limited.	Evidence gaps: There is no evidence that reinforcement of the process has resulted in risk reduction. Examples of such evidence would include: • service users' feedback • staff feedback • incident and complaint themes and trends • CPA audit results/reports
Maturity of implementation	Basic level	The trust provided as evidence the minutes of the Locality Consultant Meeting where the Community Treatment Order (CTO) transfer between services process was discussed. It was agreed that the responsible clinicians (RCs) involved in a service user's care would discuss the transfer of care face to face, or if that was not possible, by telephone.	• copy of the locality consultant meeting minutes where CTO service users transferring between services was discussed • interview with consultant psychiatrist on 14 September 2022 Evidence gap: • further minutes of the locality group. • evidence of monitoring that responsible clinicians are discussing face to face

			regarding transfer of care when patients are under CTO
Quality of assurance	Self-control	No evidence was provided to demonstrate how the trust's quality governance and assurance systems scrutinised and monitored the effectiveness of the RC-to-RC communication when a service user on a CTO is being transferred from one service to another.	Evidence gaps: • clinical audit programme • relevant quality improvement initiatives • minutes/reporting to quality governance/service users' safety forums – floor to board • service users' feedback • complaints/compliments trends

Recommendation 2	The CPA review form was not completed to Trust standard. This resulted in a missed opportunity for sharing contemporaneous information about the patient's medication and risk factors with primary care. **Action:** Dr [x] is undertaking an audit of this. **Action:** Caseload review for the whole team is being undertaken and an audit tool has been developed to be used in supervision. **Action:** A proforma has been developed to be used in MDT discussions and pathway meetings as a prompt to look at factors such as risk, engagement, capacity, safeguarding and to remind staff to check MIG. For patients on Enhanced CPA when there has been a significant change in either risk factors or medication made during care programme approach (CPA) review or the inpatient admission process, the care co-ordinator should discuss and record the future management with the GP.		
	RAG rating	Narrative	Evidence submitted
Effectiveness of intervention	Warnings, alerts, reminders, checklists	The actions rely on a mixture of human and system intervention to implement. This type of risk-reduction strategy has been found to have moderate impact in terms of changing behaviours and practice. Stronger evidence regarding the implementation and subsequent	Evidence gaps: Although the information detailed below has value, evidence to support the effectiveness of the intervention was limited and did not include: • completed supervision audit results/reports

		impact of the changes would have improved this assessment.	• completed CPA review form audit results/reports • relevant staff feedback • relevant service users' feedback
Maturity of implementation	Early progress	The trust identified four actions as part of this recommendation: • audit of CPA forms • caseload review • audit tool to be developed for supervision • proforma to be developed for use in multi-disciplinary team (MDT) discussions as a prompt for risk/engagement/capacity/safeguarding and checking medical interoperability gateway (MIG) – this enables exchange of patient information between organisations	• interviews with Crisis Team members on 9 August and 7 September 2022 • interview with serious incident investigator on 5 August 2022 • interview with care coordinator on 14 September 2022 • proforma for MDT discussion • pathway meeting minutes dated 27 November 2019 • audit tool for supervision • audit checklist • guidance for supervision • caseload audit Evidence gaps: • Dr [x] audit findings and actions arising • caseload review, audit findings and actions arising from them • evidence of communication between care coordinators and GPs regarding future management of patient on enhanced CPA
Quality of assurance	Self-control	The trust has not provided evidence of its quality governance and assurance systems that would be responsible for scrutinising and monitoring the implementation of this action.	Evidence gaps: • clinical audit programme • relevant quality improvement initiatives

			• minutes/reporting to quality governance/patient safety forums – floor to board

Recommendation 3	There were 65 risk assessments but the last 7 pulled the same information through and were not edited as per Trust standard. **Action:** When community teams assess risk, each identified factor should be cross referenced in a narrative section of the record. The triggers and any protective and contributory factors should be clearly described for each area of risk. This has been addressed by recent work around frequently asked question re risk assessment. A process has been set up to address this.		
	RAG rating	Narrative	Evidence submitted
Effectiveness of intervention	Standards & protocols	The change in process described relies on a mixture of human and system intervention to implement. This type of risk-reduction strategy has been found to have moderate impact in terms of changing behaviours and practice. In interviews with staff, they told the FM team that they felt the clinical risk management system frequently asked questions (FAQs) had helped in the quality and recording of the of risk assessments. The trust did not provide any evidence to substantiate these claims. Stronger evidence regarding the implementation and subsequent impact of the changes would have improved this assessment.	Evidence gaps: • audits to validate the impact of the new clinical risk management system FAQs and the quality of risk assessments recorded having improved • staff feedback • incident trends relating to risk assessments

Maturity of implementation	Early progress	The review team were given a copy of the clinical risk management system FAQs in order to standardise the quality of risk assessments. The practice guidance was introduced in March 2019 and was developed to support the consistent use of the clinical risk management system across the organisation. This document answers the most frequently asked questions (FAQs) and provides guidance for all clinicians on how to complete the clinical risk assessments. Discussions with staff provided some assurance that the recent work around FAQs had taken place. The FM review team felt it important to highlight a misunderstanding in the serious incident report in connection with this finding and recommendation. They found that while it appeared that clinical risk assessments were copied and pasted, in fact any previously recorded information is automatically replicated in the updated entry. Updated risk assessments can then be added as appropriate.	• interviews with crisis team members on 9 August and 7 September 2022 • interview with serious incident investigator on 5 August 2022 • interview with care coordinator on 14 September 2022 • The clinical risk management system – Frequently asked questions Evidence gaps: • CPA audits: these could provide evidence that the new clinical risk management system FAQs have had the desired effect, and the quality of recording of risk assessments has improved

Quality of assurance	No assurance	No evidence was provided to demonstrate how the effectiveness of the clinical risk management system FAQs is scrutinised and monitored through the trust's quality governance and assurance systems.	Evidence gaps: • clinical audit programme • relevant quality improvement initiatives • minutes/reporting to quality governance/patient safety forums – floor to board

Recommendation 4	The care plan was not reviewed at time of discharge from CTO. **Action:** Process to be reviewed and a reminder to be sent out to the team. To ensure that all members of the team have undertaken the CPA training.		
	RAG rating	Narrative	Evidence submitted
Effectiveness of intervention	Suggestions to 'be more careful'	The planned action relies on human rather than system intervention to implement. This type of risk-reduction strategy has low impact in terms of changing behaviours and practice. It is easy to implement, but its effectiveness in reducing risk is likely to be limited. The review team were unable to assess effectiveness of the intervention in the absence of supporting evidence.	Evidence gaps: • evidence that the care plan is reviewed at the time of discharge • evidence to ensure team members are informed to review care plan • evidence of team CPA training
Maturity of implementation	No progress	The trust has not provided substantial evidence to support the implementation of this action, for example that the process has been reviewed, a reminder had been sent to the team about the importance of reviewing a care plan before discharge, or that staff are up-to-date with their care programme approach (CPA) training	• CPA Policy v7 Evidence gaps: • evidence that the care plan is reviewed at the time of discharge • evidence that team members have been informed to review care plan before discharge

			• evidence of team CPA training
Quality of assurance	No assurance	The trust has not provided evidence how this recommendation and its actions are scrutinised and monitored by the trust's quality governance and assurance systems	Evidence gaps: • evidence of changes to the process • minutes/reporting re CPA quality and compliance to quality governance/patient safety forums – floor to board

Recommendation 5	The team did not consider the wider support available to support the case. **Action:** To remind the team of the resources available		
	RAG rating	Narrative	Evidence submitted
Effectiveness of intervention	Suggestions to 'be more careful'	The planned action relies on human rather than system intervention to implement. This type of risk-reduction strategy has low impact in terms of changing behaviours and practice. It is easy to implement, but its effectiveness in reducing risk is likely to be limited. The FM review team were unable to assess effectiveness of the intervention in the absence of supporting evidence.	Evidence gap: • how was this action was communicated to staff
Maturity of implementation	No progress	The trust has not provided evidence that team members have been reminded that wider support can be accessed in complex cases	Evidence gaps: • that team members have been reminded there are further resources that can be accessed • team members are accessing associated resources
Quality of assurance	No assurance	The trust did not provide evidence how this recommendation and its actions are	Evidence gap:

		scrutinised and monitored by the trust's quality governance and assurance systems.	• minutes/reporting to quality governance/patient safety forums – floor to board

Recommendation 6	It was noted that supervision occurred frequently; however, it is recommended that more robust and accurately recorded clinical and caseload supervision would support care co-ordination when planning care. **Action:** A review of the supervision contract is taking place to clarify roles and responsibilities. **Action:** A supervision workshop has taken place to agree processes around recording supervision and what needs to be discussed. **Action:** Review of the quality of supervision is taking place.		
	RAG rating	Narrative	Evidence submitted
Effectiveness of intervention	Rules & policies	The changes described rely on a mixture of human and system intervention to implement. This type of risk-reduction strategy has been found to have moderate impact in terms of changing behaviours and practice. Stronger evidence regarding the implementation and subsequent impact of the change, such as improvements in the quality of supervision, would have improved this assessment.	Evidence gaps: • evidence of the supervision workshop held • clinical supervision policy • review of supervision quality • qualitative/quantitative assessment of supervision • staff feedback
Maturity of implementation	Basic level	The trust identified three actions from the recommendation and provided the review team with the following: • supervision contract template	• discussion with team manager • guidance for supervision Evidence gaps: • evidence of the supervision workshop held • clinical supervision policy

		The trust confirmed there are already standards in place for all staff to receive supervision; these are detailed in the trust's clinical supervision policy, but this was not provided to the FM team. A review cycle for 2020 had been set up to assess the quality of supervisions and to ensure that the standards set out in policy and locally were being achieved. The trust did provide information that these actions have been disseminated to the locality teams or that the quarterly report stated had been shared with the South Community clinical business unit (CBU).	• findings and actions arising from the review of supervision quality
Quality of assurance	No assurance	The trust did not provide evidence how this recommendation and its actions are scrutinised and monitored by its quality governance and assurance systems	Evidence gaps: • qualitative/quantitative assessment of supervision • clinical Supervision Policy compliance • review of supervision quality • minutes/reporting to quality governance/patient safety forums – floor to board

Recommendation 7	The investigation highlighted that recommendations for changes to medication that had been sent to the GP practice were not actioned. **Action:** This has been reported as a SIRMS incident to [Commissioning Support Unit] and we await a response.		
	RAG rating	Narrative	/Evidence submitted

Effectiveness of intervention	Warnings, alerts, reminders, checklists	The change in process described relies on a mixture of human and system intervention to implement. This type of risk-reduction strategy has been found to have moderate impact in terms of changing behaviours and practice. The FM review team recognised that the trust is not in control of the implementation of this action.	
Maturity of implementation	Early progress	This recommendation is beyond the scope of the trust to monitor; however, the trust did highlight the concerns. Trust have provided email communication with the Commissioning Support Unit that provided an update: • the GP practice are re-auditing their workflow processes, and these will be amended depending on the audit findings • confirmed that the practice pharmacist should have reported that the GP had not changed the medication, as directed by the psychiatrist, as an incident	• email from the Commissioning Support Unit advising of the audit within the GP practice
Quality of assurance	Management control	The Commissioning Support Unit to monitor progress	

Section 13: Glossary

After Action Review (AAR)
An After Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future *(see references).*

Amisulpride
An antipsychotic drug used to treat acute psychotic episodes in schizophrenia and schizophrenia. It is available in tablet or oral form and only available on prescription *(see references)*

Community Treatment Order
Introduced in 2018 a CTO provides supervised treatment in the community, and provides conditions that must be complied with, which may include where someone lives and when and where treatment will be provided. If the conditions are broken or an individual becomes too unwell to be supported in the community they may be admitted to hospital.

Community Treatment Team (CTT)
This team provides assessment and treatment by a multi-disciplinary team. The team provides a specialist service for men and women between the ages of 18 and 65 years who experience severe complex mental health difficulties and require a period of assessment and treatment. Referrals are accepted from care coordinators, GPs, primary care mental health teams, local authorities or specialist mental health services. Referrals are made through the single point of access.

Dual Diagnosis
Dual diagnosis is the term used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use (*see references).*

Duty of candour
There are two types of duty of candour, statutory and professional. Both the statutory duty of candour and professional duty of candour have similar aims – to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong. The statutory duty also includes specific requirements for certain situations known as ‘notifiable safety incidents’. If something qualifies as a notifiable safety incident, carrying out the professional duty alone will not be enough to meet the requirements of the statutory duty. *(see references).*

Crisis assessment and treatment team
This is a multi-disciplinary team, that offers assessment and home treatment for people over 16 experiencing a mental health crisis, as an alternative to hospital admission. The team operates 24 hours per day, seven days per week. Referrals are accepted from: care coordinators, GPs, primary care mental health teams or specialist mental health services and self-referrals.

Mental Health Assessment and sections
The mental health action (1983) is legislation which allows medical professionals to ensure that individuals who require assessment or treatment to be admitted to hospital. This can be achieved as:

- Detention or involuntary detention
- Compulsory admission to hospital
- Being sectioned
- Being a formal patient

There are a number of sections available to be used:

- Section 5(2) - patient already in hospital
- Section 2 - admission for assessment
- Section 3 - admission for treatment

Further information is available on Cygnethealth and NHS websites (see references).

Multi Agency Public Protection Arrangements (MAPPA).
The Criminal Justice Act, 2003, requires the establishment of Multi Agency Public Protection Arrangements in each of the 42 Local Criminal Justice areas in England and Wales. Whilst not a statutory body, MAPPA requires the Local Criminal Justice Agencies to work together to manage the risk posed by relevant offenders and therefore better protect the public from harm. The Responsible Authority for MAPPA are the police, prison and probation services, other agencies have a duty to co-operate with the Responsible Authority. The Responsible Authority for specified sexual and violent offenders have a duty to ensure that the risk posed by that offender are appropriately assessed and managed *(see references).*

Multi Agency Risk Assessment Conference (MARAC).
This is a meeting where information is shared between relevant agencies in high-risk domestic abuse cases in order to assess the risk to victim(s) and to agree a risk management plan. The primary focus of the MARAC is to safeguard the victims of domestic abuse and where necessary their children, and to mitigate the risk posed by offenders *(see references).*

Nitrazepam
A benzodiazepine related sleeping tablet due to sedative properties *(see references).*

Police force
The core responsibilities of the police are to protect life and property, to preserve order, to prevent the commission of offences and to bring offenders to justice. They are also one of the core agencies responsible for safeguarding children and vulnerable adults.

Potentially Dangerous Person (PDP)
Although not defined by statute, a PDP is a person who does not qualify for MAPPA, usually because they don't have a qualifying conviction but there are reasonable grounds for believing that there is a risk of them committing an offence that will cause serious harm. Declaring a person as a PDP could initiate cross agency information sharing to support effective risk assessment and risk management plans *(see references)*.

Pregabalin
A drug used to treat epilepsy, anxiety and nerve pain. It is available in capsule, tablets or liquid form and is only available on prescription *(see references).*

Procyclidine
A drug used to treat parkinsonism, drug-induced extrapyramidal symptoms and acute dystonia. Available as tablet, oral or solution for injection *(see references).*

Protective factors
Protective factors are often the converse of risk factors and include individual resilience; control and security (financial, housing etc.); meaningful activity including quality employment; participation and social networks. They may include individuals, families or communities that support resilience, help people more effectively manage stressful events, and strengthen other characteristics that minimise the risk of mental health *(see references).*

Sertraline
An antidepressant known as an SSRI (selective serotonin reuptake inhibitor). Often used to treat depression, panic attacks, OCD and PTSD. It is available as a tablet and only on prescription *(see references).*

Single point of access (SPA)
This is a process whereby referrals are received from professionals and discussed within individual community treatment teams, who in turn provide screening and triage, allocating referrals to appropriate trust care pathways or signposting onward to non-trust services.

Step up team
This team was described to the FM review team as a service which supports people in the community upon their discharge from hospital and until a care coordinator from the CTT can be allocated.

Temazepam
A drug in the benzodiazepines group that is used to treat sleeping problems. It is available in table or liquid form. It is only available as a prescription *(see references).*

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