DUNCAN &
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Investigation, Learning, Improvement

Independent Thematic Pathway Review: In a North West England Foundation Trust

This report was commissioned by
NHS England and NHS Improvement – North West Region

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Part One

Introduction

Preface

1.1. The Independent Thematic Pathway Review (the Review) was commissioned by NHS England and NHS Improvement North West Region under the auspices of the NHS England Serious Incident Framework (2015). Five cases were selected for review where Service Users receiving care and treatment at the Trust seriously assaulted members of the public; one of the incidents resulted in death.

1.2. At the inception of the work it was agreed that the Review would primarily be undertaken as a desktop analysis triangulated by meetings with the Trust, learning events, and high-level supplementary interviews.

1.3. The national ethos for independent reviews of this kind is to establish lessons for learning with a developmental stance to facilitate service change and improvement in order to promote patient safety. It is not the purpose of an independent review process such as this to duplicate other investigation and review processes, but to provide (when appropriate) critical analysis, additional independent insights, and assurance. In the interests of learning the Trust has been annonymised.

1.4. The fundamental question set by the commissioners of the Review was:

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

1.5. The Independent Thematic Pathway Review terms of reference are provided as Appendix 1.

Acknowledgements

The Trust

1.6. The Review Team acknowledges the professionalism and courtesy extended throughout the Review process by the Trust. We are grateful for their support and assistance and appreciate the enquiring minds, transparency and enthusiasm of the staff that we worked with.

Introduction

Investigation Inception

Background to the Independent Thematic Pathway Review

1.7. In November 2020 NHS England and NHS Improvement (NHSE/I) – North West recognised that there had been a number of mental health homicide incidents and near misses where significant similarities had been identified within the Trust. At this time NHSE/I wanted to commission a piece of work that would both support the Trust and ensure that learning was embedded within current services through an appropriate review process.

1.8. Following an analyses of a number of cases four main areas of concern had been identified:

1. Clinical risk assessment and management processes.
2. Dual Diagnosis (mental health issues combined with drug/alcohol abuse).
3. Professional communication and the day-to-day working between services and across teams.
4. The quality of Trust internal investigation processes and response to Duty of Candour requirements.

1.9. At this time NHSE/I were cognisant of the Sussex-based Thematic Review conducted by Caring Solutions (2016). The report made a strong recommendation for nationally-based NHS commissioners; it stated that in future rather than ‘stop’ at the investigative and/or thematic review process/action planning stage, commissioners should seek to conduct quality reviews (evidence-based audits) to ensure all required service changes had been met and all learning taken on board.

1.10. The Caring Solutions thematic review highlighted the failure of current NHS assurance approaches which depended upon quantitative data. The recommendation was to focus on quality, evidence-base audits which could examine services in detail in order to understand the patient safety journey better. This was the model selected for this Review.

1.11. Several scoping meetings were held between November 2020 and March 2021. It was agreed that the Thematic Pathway Review would not only work with those areas of concern already identified by the commissioners – but would also:

- ascertain any additional themes that needed to be considered;
- work with themes already identified by the Trust;
- conduct a quality, evidence-based audit set against national and local best practice guidance.

1.12. The intention was to keep it simple and supportive, working in partnership by developing an evidence-based standards proforma; the proforma would comprise the national and local guidance that addressed the consistent themes identified by NHSE/I, the Trust and those also identified by the Review Team. The proforma would be developed to examine in detail the reasons behind *why* the same themes reoccurred with such frequency. In short, a return to the ethos of ‘holding up a mirror’ to provider services was advocated to assist them in identifying targeted service improvement interventions. It was also understood that the standards proforma would become an ongoing assurance tool to monitor progress moving forward.

1.13. To this end Duncan and Johnstone Consultancy Ltd (D&J) was commissioned to undertake the work.

Prior Investigation Processes

1.14. During the summer and early autumn of 2020 the Trust commissioned two comprehensive internal reports for the Trust's Executive Team.

1. **Thematic Review of Homicides (30 July 2020):** The purpose of the report was to provide an update (and a thematic review) of homicide incidents that had occurred during the past four years involving Individuals known to Trust services. This report examined 14 homicide cases. The themes identified were as follows:

    - lack of engagement;
    - diagnostic issues;
    - poor interagency working (includes communication issues);
    - resource issues;
    - inadequate care planning;
    - poor carer assessment, engagement and support.

2. **Contributory Factors Analysis from Serious Incident Investigations Conducted in 2019/20 & a Review of Homicide SI Recommendations from Four Years of SI Investigations (15 September 2020):** The purpose of the report was to provide information to the Trust Executive Team and to support organisational learning and improvement. This report examined a total of 92 serious incident investigations across the entire Trust provision (NB: approximately 60% of the incidents occurred within Mental Health Services). The themes identified were as follows:

    - impact of substance misuse;
    - care coordination;
    - referral and waiting times;
    - recognition of deteriorating mental health;
    - risk assessment and care planning;
    - medication management;
    - isolated/vulnerable service users;
    - lack of crisis management planning;
    - waits for Mental Health placement;
    - access to IT to complete assessments;
    - process for cancelling appointments;
    - disengagement from service;
    - not recognising or treating first episode psychosis;
    - lack of Mental Health input.

1.15. The two Trust reports identified a significant number of themes which dovetailed into the concerns raised by NHSE/I. The Independent Thematic Review Team embedded the findings from the two Trust reports (together with the requirements of its Terms of Reference from NHSE/I) into the guidelines within the standards proforma.

Thematic Pathway Review Team Members

The Thematic Pathway Review Team

1.16. Duncan & Johnstone Consultancy Ltd (D&J) was appointed to conduct the Review. The Review Team was comprised of individuals who are totally independent of the Trust.

Independent Thematic Pathway Review Team

Dr Androulla Johnstone

Mental Health Nursing and Systems Analyses and Governance

Experience: Androulla Johnstone has 40 years of experience in mental health care and has a background in NHS clinical and operational service delivery as well as in strategic planning and commissioning. She has held two Executive Director of Nursing Board level positions in the NHS and retains her nurse registration. Androulla held the position of CEO of the Health and Social Care Advisory Service (an investigation body set up by the Secretary of State for Health and Social Care in 1969), and has been Chair of many independent investigation panels.

Androulla has:
- chaired and/or quality reviewed a total of 80 independent homicide (HSG (94)27) and unexpected death investigations;
- chaired the Jimmy Savile Stoke Mandeville Investigation (2015) into historic sexual abuse;
- chaired the Tawel Fan Investigation in North Wales (2018) which reviewed allegations of abuse and neglect in relation to 108 patients (overseen by Welsh Government);
- led/taken part in some 45 service reviews;
- led/taken part in several hundred internal

investigation processes;

- led thematic reviews into mental health Service User homicides and suicides.

Gillian Duncan

Safeguarding, Governance and Multi-Agency Working

Experience: Gill Duncan has 40 years experience of working in health and social care, with 20 years in senior management posts. Most recently, from 2008-2015, she was Director of Adult Services at Hampshire County Council prior to this she was Assistant Director for Older People in Hampshire and her first post with the council was Director of Residential and Nursing Services. As part of her work Gill established a robust care governance framework for the service including incident reporting and links to safeguarding processes.

Prior to moving into social care, Gill was a Primary Care Trust Chief Executive and had been a Director of Nursing in a Mental Health and Community Trust. Alongside her extensive management and leadership experience she has a clinical background as a nurse, midwife and district nurse.
Gill has extensive experience of service transformation, integration of health and social care and understands the challenges of leading and managing large and complex organisations. She was a member of the Prime Minsters Nursing and Care Quality Forum 2013-2014 and was an investigation panel member of the Tawel Fan Investigation in North Wales (2018) which reviewed allegations of abuse and neglect in relation to 108 patients.

Dr Peter Wood

Psychiatry and Forensic Service Analyses

Experience: Dr Wood is the Deputy Medical Director at the Avon and Wiltshire Partnership NHS Trust (AWP). He is a consultant forensic psychiatrist and has over twenty years of experience as a consultant. He was Clinical Director for Secure Services at AWP between 2013 and 2017, is a

Medical Member of the First Tier Tribunal Service (HESC) and is Health Examiner and Medical Supervisor for the General Medical Council. He is approved under the provisions of Section 12 (2) Mental Health Act (1983) and is a Member of the Royal College of Psychiatrists.

Dr Wood also has considerable knowledge and experience of all aspects of general psychiatry for adults of working age.

Review Process

Investigation Method and Methodology

Scope

1.17. At the inception of the Thematic Pathway Review it was decided that the work would primarily be conducted as a desktop analysis triangulated by meetings with the Trust, learning events, and high-level supplementary interviews.

1.18. NHSE/I selected five Serious Incidents involving Service Users of the Trust to form the basis of the Review; these incidents took place between January 2019 and November 2020. Of the five cases: one was the homicide of a member of the public; and four were physical assaults (three of which involved stabbings).

1.19. The Thematic Pathway Review was commissioned to prepare a single overarching report. It was also commissioned to prepare an aggregated Standards Proforma (Appendix 2) compiled following a detailed analysis of the clinical records and care pathways of the five selected Service Users.

1.20. Paragraph 1.14 above sets out the Trust-based 2020 thematic review findings. It was not the task of this Review to assess *all* of the findings that the Trust identified – but to work on the Commissioner's Terms of Reference and the findings as presented by the five case studies. In the event there was a close synergy between the Trust's findings and those of the Review Team; however it should be noted that the Review Team identified a number of additional issues.

1.21. The following list represents the themes identified by both the Review Team and the Trust:

- impact of substance misuse;
- care coordination (lack of continuity of care);

- referral and waiting times;
- lack of recognition of deteriorating mental health;
- risk assessment and care planning;
- medication management;
- isolated/vulnerable service users;
- lack of crisis management plans;
- disengagement from service;
- not recognising or treating first episode psychosis;
- diagnostic issues;
- poor multi-agency working (includes communication issues);
- resource issues;
- lack of Mental Health input;
- care planning;
- poor carer involvement, assessment and support;
- access to IT to complete assessments.

1.22. The following list represents the additional themes identified by the Review Team:

- poor service user involvement, assessment and support;
- lack of robust safeguarding processes for children and vulnerable adults (with poor interagency working);
- lack of robust safeguarding/risk management processes for carers;
- lack of a proactive escalation pathway when mental health deteriorates;
- poor standards of record keeping (cut and paste dialogue often significantly out-of-date and no longer relevant – significant gaps in the record);
- problematic internal multi-disciplinary team working;
- poor inter-Trust service communication;
- lack of transparent care pathways to inform both operational and clinical input;
- poor adherence to local and national policy/best practice.

Method and Methodology

The Five Case Studies

1.23. Five cases were selected by the Commissioners of this Review. The cases were selected as being a representative sample taken from 30 incidents involving homicide and/or serious assault that had been notified to NHS England and NHS Improvement – North West over the past four years.

1.24. The Review Team was sent the clinical records for each of the Service Users whose cases had been selected for inclusion. These records included everything that was held on file by the Trust from the time care and treatment first commenced, up until the time it ceased (NB: several of the Service Users are still receiving their care and treatment from the Trust).

1.25. In each of the cases selected the perpetrator was male and aged between 21 and 43 years at the time the incident occurred.

Challenges

1.26. Accessing the clinical records took place over a ten-month period. This was for three main reasons:

1. The pressures placed on services due to COVID.
2. Difficulty in accessing the records from the Trust RiO (the electronic clinical record system) and other electronic storage systems.
3. Difficulty in accessing records held by multi-agency partners (for one particular case in the study).

1.27. The work was delayed over a sustained period of time due to the Review Team having incomplete access to records. After receiving assurances that the full Trust-held records had been sent, the work was able to commence. However it is of note that the records received were of an overly concise nature – it has not been possible to determine whether the significant ‘gaps’ were due to ongoing record retrieval issues (still in play despite Trust assurances) or whether key clinical practices (such as risk assessments etc.) were not undertaken in keeping with both national and local best practice guidance. Challenge to the Review or not – the difficulty in accessing the clinical records is a finding in its own right and is explored in Part 4 of this report.

The Process

1.28. Internal NHS incident investigation and thematic review processes often identify care and treatment factors (acts or omissions) that make a contribution to untoward incidents occurring. In a mental health context, investigation processes usually focus on the last six months of a single Service User’s care and treatment, and take a fairly high-level overview of *what* could (or should) have been managed differently. Thematic reviews group together the findings and conclusions of similar incident investigation reports and identify *where* things consistently appear to be failing across a system.

1.29. A thematic pathway review/audit takes a more detailed, longitudinal overview of the entire Service User pathway – from its inception to its end. The *actual* care pathway that a Service User followed is mapped against evidence-based standards that recognise national and local best practice guidance. By taking this approach it is possible to take an objective stance and understand the following in a comprehensive manner:

1. Has clinical practice (medication care and treatment) been managed consistently in keeping with nationally recognised evidence-based practice?
2. Do services provided alter across geographical locations and individual practitioners?
3. Are pathways managed appropriately by care coordination?
4. Are all of the accessed services and agencies coordinated and working in synergy?
5. Are clinical records accessible to all relevant treating and care teams?
6. Are Trust policies routinely being adhered to (e.g. risk management, referral criteria, Care Programme Approach (CPA), MAPPA etc.)?
7. Are Trust audit processes sensitive enough to detect regular non-adherence to policy and procedure?

1.30. If a group of cases are examined at the same time the findings are both strengthened and triangulated. The granular level of detail enables a greater understanding of the system and *why* clinical practice might not always be optimal; it also enables recommendations and patient safety actions to be targeted. Of most significance a thematic pathway approach affords the opportunity for the regular, detailed monitoring and review of clinical practice and service provision in order to provide robust, ongoing assurance to Trust Boards and commissioners.

1.31. **Stage 1:** In keeping with the Terms of Reference the Review Team considered the five internal investigation reports prepared by the Trust for each of the cases in this study. The Review Team also considered the two internal thematic reviews prepared by the Trust (as detailed in paragraph 1.9 above). A review of the five internal investigation reports and processes was undertaken (see Part 3 below).

1.32. **Stage 2:** A comprehensive narrative chronology was developed for each case based on a detailed analysis of the clinical records. This ensured a thorough, longitudinal examination of the care pathways was undertaken. At this stage the Review Team was able to validate the themes already identified by the Commissioners and by the Trust. The Review Team also identified some additional themes that had not yet been considered.

1.33. **Stage 3:** A standards proforma was developed using the identified themes as headings. The standards proforma was developed using relevant national and local best practice guidance to create a robust audit tool. The Trust provided the Review Team with the necessary policies and procedures together with other supporting documentation.

1.34. A proforma was completed for each of the cases in the Review and this data was used to create an aggregate document. The aggregate document provides an evidence-based audit which sets out in detail:

- the underlying mismatch between policy expectation and actual service delivery;
- where future improvements need to be targeted; and

- which areas will require regular audit and review to monitor progress.

2.1 **Stage 4:** Workshops and high-level interviews were held with the Trust. These events were supplemented by regular meetings and held in order to test and triangulate findings. The Review Team worked with the Trust to identify workshop participants who represented a robust cross-section of the organisation from both a management and clinical perspective; of note several of the workshop and interview participants had either led (or worked on) the Trust-based Thematic Reviews as mentioned in paragraph 1.14; consequently they were well aware of the issues requiring attention. The Trust also worked with the Review Team to prepare the participants and to organise the topics for discussion. The post holders for the workshop and high-level interviews comprised the following:

1. Executive Director of Improvement & Compliance (interviews and planning meetings);
2. Deputy Medical Director - Consultant Forensic Psychiatrist (workshop and planning meetings)
3. Associate Director of Operations No 1 (interview only);
4. Associate Director of Operations No 2 (workshop only);
5. Associate Director of Operations No 3 (workshop only);
6. Service Manager Community Mental Health Teams and Home Treatment Teams (workshop only);
7. Consultant Psychiatrists of Adult Mental Health Services x4 (workshop only)
8. Consultant Psychiatrist of Forensic Services (workshop only);
9. Clinical Psychologist Adult Mental Health Services (workshop only);
10. Nurse Consultant Community (workshop only);
11. Nurse Consultant Inpatients (workshop only);
12. Head of Allied Health Professionals/Freedom to Speak Up Guardian (Workshop, interviews and planning meetings);
13. Occupational Therapy Consultant (workshop only);
14. Community Team Leaders x 2 (workshop only);
15. Registered Mental Nurses Community and Inpatient x 7 (workshop only)
16. Forensic Speciality Nurse (workshop only);
17. Head of Patient Safety (workshop, interviews and planning meetings);
18. Governance Manager (workshop only).
19. Governance Leads x 2 (workshop only).

1.35. Following the workshop the transcript of the event was made available and each participant was invited to reflect on the day and send any clarifications and further information to the Review Team should they think it useful.

1.36. In the interests of thoroughness the Review Team developed a reflective statement template for key Trust participants to complete. However capacity pressures on Trust services due to COVID made this approach untenable. The Review Team continued to work with the Trust to establish a fair and inclusive process that could yield triangulated evidence to develop robust findings and conclusions.

Factual Accuracy process

1.37. Prior to the completion of the Review the draft report was sent to the Trust for a factual accuracy evaluation. The Review Team worked with the Trust to ensure that the findings and conclusions were triangulated and deemed to be a fair representation of the five cases examined in the study.

Part Two

Background Information

The Trust

Background Information

Information about the Trust

2.2 The Trust provides health and wellbeing services for a population of just under 2 million people. The services provided include community nursing, health visiting and a range of therapy services. Wellbeing services include smoking cessation and healthy lifestyle services. The Trust specialises in secure, perinatal, inpatient and community mental health services, including services for children and young people and patients with learning disabilities. The Trust serves the whole of the Integrated Care System footprint and at the time this report was written employed 6,956 staff, with 1112 Bank staff, across more than 400 sites, working with a multitude of partners. Care and support is provided in a range of settings. Service provision is delivered to meet the physical and mental health needs of the local population. The Trust has 26 Care Quality Commission (CQC) registered locations.

Service Configuration

2.3 The Trust’s Community Mental Health Team Standard Operating Procedure (2021) states that:

“This Procedure is based upon the following Values Based Model:

- *Quality care in the right place at the right time, every time. Robust assessment and triage*
- *One service, different functions – caring for the neighbourhood*
- *Recovery focused and enabling*
- *Responsive to service user and carer needs, in the least restrictive environment*
- *Consistency of care for service users and carers in line with the carers’ strategy – not to put an undue burden on carers*
- *Based on good relationships of trust, respect and team working*
- *Strong GP relationships*
- *Safe*
- *Effective and efficient*
- *Caring and compassionate.*

We aim to follow these key principles:

- *To collaborate with service users in planning their care*
- *To involve families and carers in planning and delivery of care where appropriate*

- *To deliver high quality treatment and care which is known to be effective*
- *To be non-discriminatory*
- *To be accessible so that appropriate treatment can be obtained when and where it is needed; To promote the safety of service users and that of their carers and staff*
- *To offer choices which promote independence; and*
- *To empower and support our staff".*

2.4 The procedure also states that the Community Mental Health Team is an umbrella term for a range of adult mental health community-based functions and interventions that are delivered by a multi-professional team, consisting of nurses, occupational therapists, clinical psychologists, psychological therapists, psychiatrists, and health care support workers. The role of the Community Mental Health Team is to provide assessment and community-based interventions, which is undertaken in partnership with referred individuals and focusses on individual needs, self-determination and recovery.

2.5 The Community Mental Health Team support and coordinate individual care planning that may involve the following services:

- Access to Accommodation & Benefits Advice;
- Biological Interventions;
- Cognitive Assessment (Psychology & Psychiatry);
- Community Care Coordination & Support;
- Occupational Therapy;
- Peer Support;
- Psychiatry Review & Intervention;
- Psychological Intervention (Individual or Group or Family or Consultation) Intensive Psychological Interventions for Borderline Personality Disorder;
- Recovery Group Residential Rehabilitation Social care interventions;
- Specialist Assessments;
- Support for families and carers (including carer support and/or contingency planning):
- Vocational & Employment Advisors.

2.6 Four of the cases in this Review were eligible for CMHT services throughout the entire period of care and treatment. One case was eligible on an intermittent basis.

Part Three

Internal Reports: Findings and Conclusions

Summary of the Trust's Internal Investigation Findings and Conclusions

Internal Investigation Findings and Process

Trust Internal Investigation Process

3.1 The Terms of Reference for this Review include the *"Quality of internal investigations including engagement with affected families post incident".*

3.2 During the Review the Trust explained that it had recently undertaken a series of improvements to its serious incident investigation process. The Review Team found the current Trust Incident Policy (effective from April 2020) to be fully compliant with the NHS England Serious Incident Framework (2015) and appropriately referenced to all other relevant good practice policy guidance. The Trust policy has a focus on organisational learning and patient safety which is good practice. A précised summary of the policy states:

1. *"Our overall purpose is to improve the health, wellbeing and independence of all our service users, patients and the public. It is a priority of the Trust to deliver care in a safe environment to protect patients, visitors, staff and the organisation from harm".*

2. *"Some incidents are classified as Serious Incidents (SIs). This is a term used by the National Reporting and Learning Service (NRLS)… [and includes] serious violent incidents involving Trust services users, staff or members of the public".*

3. *"The member of staff who identifies or is informed about the near miss or incident is responsible for informing the most senior member of staff on duty… The incident must be reported onto the Datix Risk Management System as soon as possible after the incident has been discovered and within 24 hours of occurrence".*

4. *"[The] Head of Patient Safety and Head of Safety Analytics are responsible and accountable for informing and updating the Trust's commissioners about any serious incident (SI) investigations using the electronic Strategic Executive Information System (StEIS) and for monitoring contractual targets for completion of SI investigations… [and for] overseeing investigations into SIs and ensuring that the Trust complies with the contractual timescales related to this and duty of candour".*

5. *"Comprehensive investigation for severe or incidents resulting in death /catastrophic incidents (60 working days) – led by an independent Lead Investigating Officer (LIO) reviewer and a team from a different specialty to where the incident took place. Note: Certain complex investigations requiring specialist input may be led by a corporate LIO/ team nominated by the Director of Improvement & Compliance".*

6. *"The Trust uses Root Cause Analysis (RCA) techniques and Human Factors principles to support investigations… It is not acceptable for an RCA investigation to be conducted by one person. The number of staff required as part of the investigating team will be determined on a case-by-case basis. However, as a minimum, the following roles will apply:*

    - *Lead Investigating Officer;*
    - *Medical and/or nursing / AHP (allied health professional) for any patient incident; and*
    - *A senior clinician/manager appointed as the P/FLO [Patient Family Liaison Officer] from the Network Locality".*

7. *"Additional specialist advice and input should be sought when appropriate. It is preferable for the investigation team to have members who have expertise in the area under review".*

8. *"The investigation must conclude with an investigation report, recommendations and an action plan. This needs to be written as soon as possible and in a way that is accessible and understandable to all who receive the report".*

9. *"At 45 working days, the findings and recommendations from the final report will be presented by the Clinical Director and/or the Head of Nursing at the Safety Summit for final review and ratification. This is an executive led group, which is chaired by the Executive Medical Director and has representation from the Executive Director of Nursing & Quality and the Executive Director of Improvement & Compliance. Any final amendments required from this meeting must be completed within the next 10 working days prior to submission to the CCG".*

3.3 The Review Team is aware that three of the cases occurred during the first year of the Covid lockdown in 2020 and that services were stretched beyond their usual capacity. This could reasonably be expected to have had a negative impact on Incident Investigation processes.

Synopsis of the Five Cases as set Against Trust Policy and the NHS England Serious Incident Framework (2015)

3.4 All five of the cases in this Review were correctly classified as Serious Incidents. The Review Team has kept all Service User information to the absolute minimum to maintain both patient anonymity and confidentiality.

Case 1

3.5 **Process:** The incident, a Service User-perpetrated stabbing of a family member with a prior (and post incident) attempt at suicide, took place in May 2020; the report was completed within the required timescale.

3.6 The report template was comprehensive and supported by clear and relevant terms of reference which were negotiated with internal stakeholders; the internal investigation team was appropriately constituted in keeping with Trust policy. It was also evident that witnesses were interviewed to aide clarification.

3.7 **Findings and Conclusions:** The Review Team found the history provided and the narrative account of events to be concise but relevant. The report evidences an appropriate use of the Root Cause Analyses methodology. A precis of the findings are as follows:

- referral delays;
- resourcing issues;
- inadequate risk assessment processes;
- non-adherence with Trust policy guidance.

3.8 Evidence-based root causes and contributory factors were identified.

3.9 **Organisational Learning:** The report template provides a clear and concise summary of organisational learning for the attention of all Trust staff – this is good practice. The report also details remedial safety actions to prevent reoccurrence in the short-term – this is also good practice.

3.10 **Recommendations and Action Plan:** The recommendations are relevant and targeted. The action plan is clear with identified, named individuals responsible for implementation.

3.11 **Review Team Feedback:** The Review Team found the investigation process and report to be competent and in keeping with Trust policy.

Case 2

3.12 **Process:** The incident (a Service User-perpetrated non-fatal stabbing of their ex-partner) took place in May 2019; the report front cover sheet is incomplete and it cannot be ascertained whether the investigation was concluded within the required timescale. It remains unclear from reading the report how it was reviewed and what the sign-off process was.

3.13 The report template was adequate and the terms of reference were sound – however the report is highly narrative in style with a great deal of attention given to the Service User's history and not enough to investigation analysis. No lessons for learning were identified and no recommendations were made. It would appear that the Lead Investigator conducted this investigation as a lone investigator – which is counter to the Trust's policy when grading an incident of this kind.

3.14 **Findings and Conclusions:** The findings and conclusions focused on areas of good practice (under the heading of Notable Findings). The findings also focused on the Service User having been processed through the Criminal Justice system for the assault, the implication being that the assault was not driven by mental health issues and therefore a more in-depth analyses was not required *"The Service User's crime has been managed through the criminal justice pathway, which infers that he maintained criminal responsibility throughout the process; he is currently serving a custodial sentence in prison".*

3.15 **Organisational Learning:** Please see paragraph 3.13 above.

3.16 **Recommendations and Action Plan:** No recommendations were set and no action plan was developed.

3.17 **Review Team Feedback:** The Review Team found that regardless of whether the Service User was deemed to be responsible of his actions or not (in relation to the assault) there were significant lessons for learning to be identified. A detailed examination of the Service User's clinical records demonstrates key omissions in service – which (whilst they might not have contributed to the incident itself) were of significance; an important opportunity for learning was missed.

Case 3

3.18 **Process:** The incident (a Service User-perpetrated assault of three members of the general public) took place in November 2020 – the Service User had gone Absent Without Leave (AWOL) from an inpatient setting. The report does not detail when the investigation was completed or how the process was reviewed and signed off.

3.19 The report template was comprehensive and supported by clear and relevant terms of reference – however it is not clear how they were reviewed and negotiated. The internal investigation team was not appropriately constituted in keeping with Trust policy given the seriousness of the incidents. It was good practice to have engaged with key ward-based witnesses – witnesses were also able to state that they had been given good support post-incident.

3.20 **Findings and Conclusions:** The Review Team found the history provided and the narrative account of events to be a reasonable summary. The report evidences an appropriate use of the Root Cause Analyses methodology. A precis of the findings are as follows:

- issues around AWOL procedures;
- issues around staff safety alarms;
- poor recording of leave information;

- recognition that some Service Users can mask their condition;
- the need to re-assess the Service User (post incident) regarding future levels of risk.

3.21 **Organisational Learning:** The report template provides a clear and concise summary of organisational learning for the attention of ward staff – this is good practice; however the Review Team is of the view that this learning should have been available to all inpatient settings across the Trust – not just to a single ward. We note that the report author suggests the learning should be Trust-wide (at the end of the report) it is not clear whether this was achieved.

3.22 **Recommendations and Action Plan:** The recommendations are relevant and targeted to the ward (however they might have been more helpful if applied for review across the Trust's entire inpatient provision). The action plan is clear with identified individuals responsible for implementation.

3.23 **Review Team Feedback:** The Review Team found the investigation process and report to be competent and in keeping with Trust policy.

Case 4

3.24 **Process:** The incident (a Service User-perpetrated non-fatal stabbing of a family member) took place in April 2020. The report was completed just outside the recommended timeframe. The report describes staff support and debriefing processes – this was good practice. It would appear that the investigation was managed by a single practitioner with support from a Safety and Learning Review Specialist – this was not in keeping with Trust Policy for a serious incident of this kind.

3.25 There was a significant use of policy guidance to benchmark the findings against; this was good practice. The history provided, and the narrative account of events were concise but relevant.

3.26 **Findings and Conclusions:** The report evidences an appropriate use of the Root Cause Analyses methodology. A precis of the findings are as follows:

- issues with record keeping, professional communication and risk assessment formats;
- pressures with workforce capacity;
- gaps in policy provision regarding Service Users not subject to CPA on the recovery caseload.

3.27 No root causes or contributory factors were identified.

3.28 **Organisational Learning:** The report template provides a clear and concise summary of organisational learning for the attention of all Trust staff; this is good practice. The report also details remedial safety actions to prevent reoccurrence in the short-term; this is also good practice.

3.29 **Recommendations and Action Plan:** Two recommendations were made; they were relevant but did not reflect the totality of the report findings. The action plan is clear with identified individuals responsible for implementation.

3.30 **Review Team Feedback:** the investigation report demonstrates an evidence-based approach. The findings were robust in relation to the events directly leading up to the incident; the findings also had significance for the Trust as a whole.

Case 5

3.31 **Process:** The incident (a Service User-perpetrated homicide of a member of the public) took place in January 2019. The report was completed 18 months after the incident – the Trust has not been able to explain why this was – however it would seem that the Service User was not receiving care and treatment from the Trust at the time of the incident and it apparently took several months before the Trust was made aware of the homicide. This is unsatisfactory as Trust personal assessed the Service User in a prison cell directly after the homicide – therefore the Trust should have been alerted to the homicide at this stage. The Trust could not detail subsequent events or why the internal investigation finally took place 18 months later. It is of note that the incident was reported to commissioners some 11 months after it took place – well outside of the required timeframe.

3.32 It would appear that the investigation was managed by a single practitioner with support from a Safety and Learning Review Specialist; this was not in keeping with Trust Policy for a serious incident of this kind.

3.33 A mental health related homicide is of the utmost seriousness – it would be usual for a multidisciplinary team to be constituted to undertake the investigation and it would also be usual for clinical witnesses to be called. This was not achieved. The terms of reference are of a poor standard and fall short of what would usually be expected for a case of this kind.

3.34 **Findings and Conclusions:** it is not clear how the Lead Investigator developed the findings and conclusions in the report – a great deal of the information provided is not correct and consequently the report apportions undue responsibility to the Service User for disengagement without exploring and understanding the significant reasons why.

3.35 Good practice was identified – however the Review Team could not replicate these findings on a close examination of the clinical record.

3.36 **Organisational Learning:** No organisational learning was identified.

3.37 **Recommendations and Action Plan:** No recommendations were identified and consequently there was no action plan.

3.38 **Review Team Feedback:** The Review Team found that the internal investigation and the subsequent report were not fit for purpose and did not meet the minimum requirements for a case of this seriousness. The report made a series of incorrect and unreliable findings which have had an ongoing negative impact on the Service User and his family.

Engagement with Service Users and Affected Families Post Incident

National Policy

3.39 The NHS England Serious Incident Framework (2015), which was in place at the time these incidents were investigated, provides clear guidance when involving carers, patients, victims and their families; it states:

> *"The needs of those affected should be a primary concern for those involved in the response to and the investigation of serious incidents. It is important that affected patients, staff, victims, perpetrators, patients/victims' families and carers are involved and supported throughout the investigation".*

3.40 The Framework also states that:

> *"An early meeting must be held to explain what action is being taken, how they can be informed, what support processes have been put in place and what they can expect from the investigation. This must set out realistic and achievable timescales and outcomes… They must also have access to the necessary information and should:*
>
> - *Be made aware, in person and in writing, as soon as possible of the process of the investigation to be held, the rationale for the investigation and the purpose of the investigation;*
> - *Have the opportunity to express any concerns and questions. Often the family offer invaluable insight into service and care delivery and can frequently ask the key questions;*
> - *Have an opportunity to inform the terms of reference for investigations;*
> - *Be provided with the terms of reference to ensure their questions are reflected;*
> - *Know how they will be able to contribute to the process of investigation, for example by giving evidence;*
> - *Be given access to the findings of any investigation, including interim findings;*
> - *Have an opportunity to respond/comment on the findings and recommendations outlined in the final report and be assured that this will be considered as part of the quality assurance and closure process undertaken by the commissioner…;*

- *This may disclose confidential personal information for which consent has been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice, where required. NHS England is currently seeking advice in relation to the development of national guidance available to further support this matter. In the meantime, advice should be sought in relation to each case.*
- *Support during and after the investigation. This may include counselling or signposting to suitable organisation that can provide bereavement or post-traumatic stress counselling…"*

3.41 The NHS England *Information for Families of Victims Following a Mental Health-Related Homicide* (April 2019) was specifically written in relation to homicide, however it contains important guidance which should also be transferable to those victims who have survived mental health-related serious assaults (such as stabbings). The guidance states:

> *"NHS investigations are conducted for the purposes of learning to prevent recurrence… Management of all health-related incidents, including homicides should be in line with the Serious Incident Framework and the Duty of Candour. Duty of Candour is a statutory duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused, or could lead in the future, to significant harm".*
>
> *"The Mental Health Provider who was caring for the alleged perpetrator will be in touch with you as soon as possible after the incident. There might be a delay if the Police advise the Mental Health Provider that contact would not be appropriate at this point in time.*
>
> *You will be offered a meeting with a member of the Mental Health Provider. This can be in person at a location of your choosing or a telephone call, if this is your preference. The Mental Health Provider will explain the investigation process to you and this will be inclusive of the following:*

- *the extent of the investigations, such as; what will be reviewed/looked into and the reason for it*
- *your comments in relation to the extent of the investigation*
- *your questions in relation to the incident*
- *name(s) and contact details of those investigating the incident*
- *how would you like to be kept informed on the progress of the investigation (i.e. by e-mail/telephone and frequency of contact)*
- *commenting on draft reports before they become final*
- *future meeting(s) to discuss the findings of the investigation and what will happen next*

- *advice on where to get support, such as counselling if appropriate, or independent advice.*

  The Duty of Candour is a statutory duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused, or could lead in the future, to significant harm. Families should be told what happened as fully as possible, and in a sensitive way, in person. This should be done as soon as possible after the incident is known about, and it should include an apology".

Trust Policy

3.42 The current Trust Incident Policy (effective from April 2020) defines its responsibility under Duty of Candour thus *"This is the legalistic term which describes being open and honest in communication of patient safety incidents or serious data security breaches that result in moderate or severe harm or death with the patient, service user and family members… SI investigation reports must be shared with key interested bodies including patients, carers and their families".*

3.43 *"The support of those affected when an investigation is undertaken, is of primary importance for the Trust as part of its processes for the investigation of incidents. It is important that affected patients, service users, families, carers and staff who are involved are supported throughout the investigation".*

3.44 *"On conclusion of any investigation graded moderate, severe or catastrophic within and no longer, than 10 working days, the patient/family or carer must be contacted directly and asked how they wish the findings and outcome of the investigation to be shared. This must be followed up by a letter explaining that the investigation has completed and offering an apology and an invitation to meet to discuss the report if they so wish".*

Case 1

3.45 **Service User:** At the time the internal investigation took place the Service User was detained under the Mental Health Act (1983). After consultation with the Responsible Clinician it was agreed that any contact with the Service User would be detrimental to his health. To this end he was not involved with the investigation. At the completion of the investigation the Service User's condition remained unaltered and it was agreed the report would be shared once his mental state had stabilised. The Review Team are of the view that this was good practice and that the Trust worked 'in the spirit' of the Duty of Candour/Being Open requirements in a responsible manner.

3.46 **Family Member (who was also the Victim):** The internal investigation report details that the Lead Investigator planned to ask for consent (presumably from the Service User/perpetrator) before sharing the report with the Family Member (and victim); it is important to note that this individual was also the nominated main carer. It is recorded in the investigation report that *"On 7 May 2020, an initial assessment of the incident took place between the Safety Department's Duty Investigator and the Interim Associate Director of Safety. It was agreed that the Duty of Candour only applied to the service user, not the person affected by the incident … [a family member]. It was however agreed that efforts would be made to engage the service user's … [family member] in the post-incident safety review as part of the Trust's 'Being Open' procedure".*

3.47 The Lead Investigator met with the family member and offered an apology on behalf of the Trust *"The post-incident safety review process was discussed and the existing terms of reference shared. The service user's … [carer] was invited to add additional terms of reference; however, no additional terms of reference were added during this meeting".*

3.48 It was also written that *"Upon completion of the post-incident safety review, and if consent to share the document is gained from the service user, the Lead Investigator will write to the service user's … [carer], offering a copy of this report and an opportunity to meet/speak with the Lead Investigator to discuss the review process and the subsequent recommendations".*

3.49 **Review Team Feedback:** The Review Team concludes that the agreed management plan in relation to the Service User was entirely appropriate given the circumstances.

3.50 The Family Member/Victim was offered support; this was good practice – however it was not possible to understand whether or not a more assertive offer should have made. It should be noted that the Family Member had been stabbed – this constitutes a significant and traumatic event.

The Review Team found the thinking in relation to the Family Member/Victim's involvement to have been contradictory. Current NHS investigation practice requires for those who have come to harm to be involved in full with both internal and independent NHS investigation processes (at the very least they should be asked to provide an account, in their own words, of what transpired). It is evident that the Lead Investigator did not want to breach patient confidentiality – but this is at odds with the NHS general guidance in involving carers, families and victims of assault during an investigation process. The withholding of the report unless the Service User gave consent may also be at odds with current NHS guidance for those who have come to harm (especially when the incident of harm is subject to an NHS investigation process). The Review Team recognises that this is a dilemma for many NHS Trust Lead Investigators – however the Trust should consider the wording of its Incident Policy and more specific guidance should be provided.

Case 2

3.51 **Service User:** There is no mention made in the internal investigation report that the Service User was contacted at any stage during the process.

3.52 **Family Member/s and Victim:** The internal investigation report stated *"The statutory duty of candour is not applicable in this case as the victim of the Service User's crime was not receiving care and treatment from … the Trust*". There is no mention made in the internal investigation report that the Service User's family was contacted at any stage during the process.

3.53 **Review Team Feedback:** The Review Team found that Duty of Candour responsibilities (as set out in the Trust's incident policy) were not met. In relation to the Service User the explanation provided by the internal investigation report focused on him having been processed through the criminal justice system and that Duty of Candour processes did not apply. This was erroneous – the Service User was a patient with the Trust and all due process in relation to him should have been followed; it was not.

3.54 The victim of the stabbing was not contacted; this was not keeping with either national or local best-practice guidance.

Case 3

3.55 **Service User:** The Service User was communicated with in an appropriate and timely manner. COVID restrictions were worked with and the Service User was consulted via Teams whilst he was an inpatient; full support was provided to him. The Service User became distressed and another meeting was arranged one month later. This was good practice. It remains unclear whether the report and its findings were shared with the Service User – however the Review Team can see that there was a plan of some kind to *"ensure that the patient and their family members are kept up to date with the progress of the investigation but also to act as a point of contact to raise concerns on behalf of the patient / family. It is the sincere hope of the investigating team that this investigation process has addressed all of the issues that the patient/ family have sought to have examined and explained in regard to the incident".* This was also good practice.

3.56 **Family Members and Victims (members of the public):** Service User consent was gained in order for the Lead Investigator to make contact with them. Given the seriousness of the incidents it might have been good practice for the family to be involved in their own right in order to provide information to the Lead Investigator and to ensure their concerns were addressed. The Review Team recognised (as in Case 1) that this is a dilemma for many NHS Trust Lead Investigators – however the Trust should consider the wording of its Incident Policy and more specific guidance should be provided.

3.57 The report did not mention the victims of the assaults, how they were communicated, supported, and engaged with. This was a significant omission given the seriousness of the incidents and the significant harm caused.

3.58 **Review Team Feedback:** The Review Team found some good practice – however it should be noted that the victims of the assaults were key stakeholders and this did not appear to have been accommodated appropriately under both Trust and NHS England guidance.

Case 4

3.59 **Service User:** The Lead Investigator was unable to make contact with the Service User as he was detained in prison and contact was not possible.

3.60 **Family Members (one of whom was also the Victim):** It is not clear from the report narrative what steps were taken to contact the Service User's family, one of whom was the victim. The report states *"Despite attempts to find contact details for the Service User's family these have not been sourced, consequently there are no additional terms of reference from the family".*

3.61 **Review Team Feedback:** The Service User's father had regular contact with services; however we could not find contact information and this finding is telling in itself as family contacts should have been included in the clinical record. In cases like this the Review Team would expect the Trust to make contact with Police Family Liaison Officer to make connections on behalf of the Trust. This should have been pursued further. The Trust should also have continued to seek contact with the Service User as being in prison should not have created a permanent barrier to communication.

Case 5

3.62 **Service User:** No attempt appears to have been made to contact the Service User – the report makes no mention of this aspect.

3.63 **Service User's Family Members and Victims' Family:** No attempt appears to have been made to contact either the family of the Victim or the family of the Service User.

3.64 **Review Team Feedback:** The lack of contact and the failure to adhere to the Duty of Candour process has since been acknowledged by the Trust. When a mental-health related homicide occurs every care should be taken to contact and support key stakeholders. The case was complex and it is evident that the Trust was not aware of the homicide for a period of time – however the Trust recognises that the level of practice as illustrated by the investigation process and consequent report is not the standard it aspires to.

Summary

In General

3.65 The Review Team found the Trust's Incident Policy to be well written and fit for purpose. The Review Team has significant experience in reviewing and assessing Mental Health Trusts' internal investigation reports across England. Standards across England are variable; the five cases that were examined in this study were also variable. The Review Team is aware that improvements to the incident process were being implemented during the period the five internal investigation reports were written (and had yet to be embedded in full) – the Review Team is also aware that significant COVID challenges were in play.

3.66 Across England internal investigation reports tend to focus on the six-month period prior to the incident occurring; in many cases only the few weeks directly prior to the incident are considered in depth. Often this is sufficient to identify key causal and contributory factors and areas for learning and service improvement (under the previous NHS England framework). However the 60 day timeframe and the limits to the protected time for lead investigators means that (at times) a relatively superficial set of findings and conclusions are made; the risk of this occurring is heightened when a serious incident is investigated by a lone individual without the benefit of multidisciplinary inputs. The Trust has not been able to provide its own reasons why the five reports are so variable in quality – the Review Team can only suggest that the issues as set out directly above played a part.

3.67 All five of the cases in this study made some useful findings, but the standard was variable with the most recent incident reports obviously benefitting from the significant improvements that the Trust has made to its process (apart from Case 5). The main feedback from the Review Team is that key areas (such as diagnostic process, risk assessment, care planning, and professional communication) have not been examined in sufficient detail; these aspects are essential as they represent the basic building blocks of care safe service depends upon. These are often the underlying reasons for poor clinical outcomes, particularly when systems are examined. These omissions have perhaps provided a false assurance. A closer examination would have yielded significant non-adherence to Trust policy guidance, together with some ongoing inter-linking service issues over a considerable period of time.

3.68 The Review Team also found that the reports were often not accurate when stating matters of 'fact'. Once again this was due (in part) to the focus on the weeks and months directly before the incidents took place. Had a more granular and longitudinal stance been taken it would have become apparent that care plans and risk assessments were often 'cut and paste', out-of-date – and bore no relation to the day-to-day content of the contact sheets. It would also have become apparent that incorrect information was handed down over time due to a lack of routine vigilance and poor record keeping; this was exacerbated by a general poor standard of professional communication.

3.69 The Review Team recognises, that in general, Trust Lead Investigators can only spend a limited amount of time on each case and that the subsequent findings (and any consequent thematic reviews) will also be limited. This adds credence to the notion that Thematic Pathway Review audits are a complimentary process to support investigation work to maximise learning, service improvement and patient safety. Key points for this particular Trust to consider are as follows:

- the need for more robust and detailed Terms of Reference that address basic building blocks of care (this to support systems learning);
- the need for internal investigation processes to be supported by appropriate investigation teams and not lone individuals (in keeping with Trust policy);
- that detailed internal investigation archives are kept detailing method (a sensible requirement for Inquests and future Independent Investigation processes);
- serious cases (such as Service User-perpetrated assault and homicide), should involve clinical witnesses from treating teams to aid clarity and to increase learning;
- internal investigation reports should detail how the treating teams under investigation have investigation findings fed back to them (the Review Team could not always understand how this was achieved);
- investigation reports should detail how recommendations have been developed and with whom.

Communicating with Service Users, Families and Victims

3.70 **Service Users:** The five cases under review demonstrate variable practice. In the main significant attempts were made to engage with the Service Users. However (if for any reason) it is not possible to contact a Service User during the course of an investigation (e.g. because they are in prison or unwell) attempts should continue until such time as the Trust is certain either: no contact can realistically be made, or the Service User categorically does not wish for contact. Duty of Candour does not end at the close of an investigation process – and neither should it be the sole responsibility of the Lead Investigator. Arrangements should be made for named officers to continue this process (if either needed or required) long after the role of the Lead Investigator comes to its close.

3.71 **Families and Carers:** The Trust’s mode of working with families appears to be more confused than its process for working with Service Users. Both national and local policy guidance requires that families are communicated with in relation to serious incidents. The Review Team understands that this is a difficult area in relation to patient confidentiality – however it can never be accepted that family members are not contacted because *"Duty of Candour does not apply to them"*. NHS England requires full family and victim involvement – especially if they are the main carers and/or the victims of the assault under investigation. The Review Team understands that every case needs to be assessed on its own merit and that a 'one size fits all' approach cannot uniformly be taken – however the NHS England patient safety frameworks (past and present) represent a significant duty for the Trust to uphold and a more robust approach needs to be taken in keeping with the wording of its own policy and also national guidance.

3.72 **Victims and/or those who come to Harm:** The victims of the assaults were not contacted in their own right *"as they were not Service Users of the Trust".* This stance goes against both local and national policy guidance. The Review Team has identified this as a key area for future action and improvement.

Part Four

Thematic Pathway Review: Findings and Conclusions

Thematic Pathway Review

Overview to Chapter

4.1 The findings set out below are supported by several hundreds of pages of objective and cross-referenced evidence particular to the five cases subject to review. In the interests of Service User privacy, and due to the nature of the desk top analysis, detailed, patient-sensitive information has not been included in this report; however in the interests of fairness and transparency it has been made available to the Trust, the commissioners and for legal review. To this end the report contains concise findings without detailing intrusive clinical record content. The content of this report has been subject to factual accuracy examination by the Trust.

4.2 Each member of the Review Team took the lead for the areas of their own speciality. The analysis of the findings is the consensus view of the entire Team following all due process being met.

4.3 Findings under report sub headings titled ‘Findings from the Desktop Review of the Clinical Records’ have been taken directly from clinical records and are based factually upon them. The analysis provided has been set against objective local and national evidenced-based standards and guidelines (please see appendix 2).

4.4 Findings under report sub headings titled ‘Reflections from the Workshop Held with the Trust’ have been taken directly from workshop transcripts. The Review Team has not adjusted them in any way and they are offered here as insights, reflections and evidence in their own right. The Review Team recognises that the workshop findings represent a ‘snapshot in time’ that does not take into account any progress since made; however this is considered in the ‘Progress the Trust has Made’ section of the report and is set out below. The findings from the workshop speak to the systemic issues relevant to this Review. These findings explain and triangulate the findings from the clinical records and also provide insights as to how systems worked and where they need to be improved.

4.5 Findings under report sub-headings ‘Conclusions’ are the consensus view of the entire Review Team and have been developed in an objective and evidence-based manner using both local and national evidence-based standards and guidelines (please see appendix 2).

4.6 This Report section should be read in conjunction with the Standards Proforma where specific detail is provided. The aggregate Standards Proforma is provided as Appendix 2. Several of the themes identified above (paragraph 1.14) have been combined under lead headings in order to provide a coherent narrative. The ordering of the theme headings below is in keeping with, first: those identified by the Trust and verified by the Review Team and, second: those (identified in addition) by the Review Team alone. The exception is the Record Keeping and Professional

Communication Theme which is taken out of sequence; this is because it is important the reader understands the difficultly the Review Team experienced in assessing the data it was given to examine and the reasons why.

4.7 The underpinning evidence that supports the findings has been drawn from a documentary review of the clinical records, input from clinical staff via workshop activity, corporate interviews and meetings with the Trust on an ongoing basis. It should be noted that there is a great deal of interconnectivity and overlap between the themes and that it is only possible to understand where future actions need to be targeted by understanding this.

4.8 Key terms and phrases are explained in the glossary.

Record Keeping and Professional Communication

Findings from the Desktop Review of the Clinical Records

4.9 The Review Team found that the clinical records reviewed across all five cases identified the following:

1. Overly Concise recording of clinical information.
2. Significant gaps in the clinical record (e.g. a virtual absence of risk assessment documentation in some of the cases that were reviewed).
3. The relative absence of notes written by medical members of the multidisciplinary team.
4. Significant examples of ‘cut and paste’ (particularly with regards to risk assessments and care planning documentation).
5. Inaccuracies in the clinical record (due to ‘cut and paste’ practice which meant records were not always updated appropriately).
6. The incomplete filling in of forms and other documentation (e.g. referral forms, carer assessments etc.).
7. A virtual absence of multi-agency documentation/communication (as evidence of liaison and joint working) even when Probation and Social Services were involved.
8. No evidence (in the clinical record) to suggest assessments, planning, and other general information, was shared across Trust-based services.
9. A good standard of record keeping within inpatient settings.

4.10 During the first few months of the Review the Trust and the Review Team worked together to identify a full set records for each of the five cases in the study. It was evident that the Trust experienced retrieval issues. After a period of time the Trust confirmed that full sets of records had been sent.

4.11 At interview and during workshop activity the Trust explained the complex range of disparate IT systems that were in place – different systems were operated by different services within the Trust and this sometimes made access and information sharing difficult. The Review Team was also told that RiO (the main patient record system which has only been implemented for 18 months) was complex and time consuming to use – this meant that certain fields were not always accessed and utilised.

4.12 The Review Team remains uncertain as to whether a complete set of records has been shared (not due to any wish on the part of the Trust to be unhelpful) but because of access and retrieval issues. This is an important finding in its own right; if records cannot be accessed for audit/investigation processes – then it is reasonable to assume that neither are they readily available in ‘real time’ for the clinicians treating patients.

4.13 The Review Team found little evidence of inter-service/multi-agency communication. This was of concern as most of the Service Users in the study were open to multiple services and agencies; these Service Users also presented significant and known risks – both to themselves and others.

4.14 During meetings with the Trust (and during corporate-held interviews) the Review Team was told that the Trust had several different clinical record recording systems in play; not everyone had access to them. It remains unclear what impact this might have made to the cases examined for the Review – but it appears to be a problem that is known throughout the Trust when accessing and retrieving patient information.

Reflections from the Workshop

4.15 From an internal Trust perspective it was recognised that there was inconsistency in the access that people had to different patient record systems across different teams; it was felt this posed a huge risk. Examples were discussed where even managers (on occasions) had not been able to access the clinical recording systems of the services that they were responsible for. The workshop participants attempted to ‘count up’ the number of recording systems that were operating across the Trust, but this proved to be outside of their actual knowledge; they reflected *“when you don't have access to them, what does that mean?… it's just massively frustrating to staff”.*

4.16 Workshop participants were completely honest in their views; the general consensus was that professional communication did not happen as well as it should – particularly with multi-agency partners. *“Getting hold of people”* was seen as being a real challenge – particularly when seeking timely information to aide interventions. On reflection it was thought that the Trust information sharing protocol was not clear and that access to Social Services (or third sector agency) information was a challenge; it was also recognised that Trust information sharing protocols did not always match those of other agencies. Having 'read only access' to GP records and safeguarding systems was identified as something that would *"help massively".*

4.17 Caseload overload (and a general lack of time) was seen as a genuine reason why community-based staff did not complete clinical records in either a timely or *"high quality"* manner. The possible use of Dictaphones was discussed – it was noted that consultant psychiatrists had access to them (and also a pool of staff to transcribe the audio notes). The question was *"could that be extended to our care coordinator colleagues"*? It was noted that some staff were already using their work phones to record notes; they then transcribed the information via email which could then be cut and pasted into RiO.

4.18 The disparity between the quality of inpatient clinical records and those of community services was seen as being due to different ways of working. Inpatient services had no travel time to hinder record keeping, and there was access to the Multidisciplinary team on a daily basis; this meant the clinical record had regular and timely inputs from the whole team.

4.19 Clinical record keeping and professional communication were integral factors with most of the themes in the Review. The workshop participants also considered other reasons why record keeping was not optimal and why professional communication (both regarding inter-Trust services and those with multi-agency services) often failed. In summary these are as follows:

- the increasing use of relatively junior and inexperienced staff who fill in forms/documentation templates in an overly concise and *"bland"* manner (this was exacerbated by a lack of supervision and multidisciplinary team *"sign off"*);
- Trust templates (e.g. risk assessment and CPA forms) were too simplistic and often missed key fields (such as those for safeguarding children); this rendered the omissions 'invisible' to Trust audit processes;
- the practice of 'cut and paste' from previous documents was seen as means of saving time and ensuring audit compliance (in that audit only picked up whether templates were filled in and did not undertake a longitudinal quality review of the records);
- there are too many documents to fill in, described as *"too much paperwork"*; the multitude of different documents served to fragment assessments and increase the amount of time needed to complete them – the view was that documents needed to be aggregated; this would be more patient-centered and would also save time;

- difficulties in contacting GPs, Social Service partners etc. in a timely manner – things could ‘slide’ and key information was missed;
- RiO was difficult to navigate; some of the *“tabs”* were difficult to locate and it was a laborious and time-consuming task for clinicians to access and collate relevant information (such as psychiatric histories and risk assessments);
- Caseload overload meant that multidisciplinary and multi-agency discussions were often compromised; this made a direct impact on the both the quality of the information recorded and general professional communication processes.

Summary

4.20 The workshop inputs validated many of the findings from the desktop review of the clinical records. The issues regarding the many different electronic record-keeping systems were also discussed during various meetings held with the Trust.

4.21 The Review Team found the issues regarding clinical records and professional communication to be multi-faceted. There was no single factor identified – instead there was a complex interweaving of a multitude of blocks and barriers.

4.22 The Review Team notes that on occasions internal investigation findings have focused on the record keeping of individual practitioners. However a closer examination of the situation has demonstrated that the problem is wide-ranging encompassing individual practitioners, teams, services and systems alike.

Diagnostic Practice, Missed Psychosis and Substance Misuse/Dual Diagnosis

Findings from the Desktop Review of the Clinical Records

4.23 Examination of the five cases in the study identified the following:

1. Psychiatric history taking was variable and dependent on the kind of mental health service a patient was in receipt of; of concern was that histories developed by one Trust-based service were not necessarily accessible to other Trust-based services.

2. Mental State Examinations (MSEs) were not easy to evidence. The clinical record would suggest that MSEs were not usually conducted – the best examples were developed prior to 2015. In some cases no MSEs were recorded for years at a time – despite the clinical presentation warranting a formal review.

3. The diagnostic process followed was easy to understand in two cases. However with the remaining three cases no narrative or rationale was

provided for the diagnoses given. Diagnostic ambiguity was a hallmark of these three cases, which persisted for several years. The affected Service Users would often accrue a number of different diagnoses – but no formulation was seemingly developed and/or recorded as to how they (substance misuse, PTSD, Personality Disorder, Psychosis etc.) could possibly interact together; neither was a formulation developed to select and/or prioritise the care and treatment approach, and/or to understand risk.

4. A close examination of the clinical record reveals that each of the five Service Users reviewed experienced psychotic symptoms on a frequent basis; they were prescribed anti-psychotic medication accordingly. However there was a seeming resistance to diagnose these individuals with psychosis or Schizophrenia. The concise nature of the clinical record makes it difficult to understand what the impact of this was – however in the case of one Service User it was possible to demonstrate that this has had a significant and ongoing negative impact upon him.

5. The involvement of Service Users and Carers worked well in three of the cases reviewed. However in two cases this was not achieved; there was a breakdown in the therapeutic relationship and disagreements about the diagnostic and treatment approach. These two cases were complex with multi-service and multi-agency inputs – they could have benefitted from a second opinion and/or complex case review. However services appeared to have worked in individual silos and there was virtually no partnership working in the best interests of these patients.

6. Referrals for advice/specialist inputs were infrequent. For example: each of the five cases had significant substance misuse issues which made a significant impact on levels of risk. The clinical records have virtually no narrative present for how substance misuse was managed (apart from advice to the Service User to stop). A common feature was the tendency to ‘hold on to a case’ (perhaps for a year or two) before considering a referral – the clinical records are concise and it is not possible to track referral outcomes.

4.24 There appears to be a prolonged period of time taken to come to a diagnosis (sometimes three or four years). A notable feature is that some Service Users ‘collected’ multiple diagnoses depending on which team they were currently under (sometimes five or six different diagnoses were offered). The clustering tool served to add an additional layer of complexity – often citing diagnoses and pathway criteria that were at odds with other documentation (e.g. letters to GPs, referral letters, CPA etc). The lack of providing a diagnosis/differential diagnoses made the use of the clustering tool problematic as it was not clear which pathway a Service User should be on and which care cluster they belonged to. This also impacted on medication choices (e.g. antipsychotics prescribed for Service Users who were recorded as **not** being psychotic) and on occasions, the therapy model chosen. It should be understood that antipsychotic medication can sometimes be prescribed for non-psychotic conditions. However if prescribed in the absence of psychosis a clear rationale should to be provided within the clinical record – this was not achieved.

Reflections from the Workshop

4.25 The workshop held with Trust clinicians explored the issue of diagnosis. This was a theme that had been identified by both the Trust and the Review Team. At the workshop the general consensus was that in relation to psychiatric history taking *"some of that art had been lost… the art of history taking has gone and some of us in the group are of an age where as trainees ourselves, we would have been tasked with taking history, gathering information, getting old notes, collating things and creating a formulation".* This reflection is based on the national changes to medical staffing and mental health service reconfigurations that took place over 12 years ago. The workshop focus group also recognised that psychiatric histories (when they were done) were not updated and were often incomplete.

4.26 Workshop reflections also included the challenges posed by the RiO system whereby letters and historic PDF documents (hard copy records created prior to the electronic system) are often stored in fields that are not easily accessed – this currently facilitates potential 'discontinuity'. It was recognised that GP letters, psychology assessments and historic information are all stored in separate fields – this meant that a degree of 'searching' was required which was laborious and could lead to things being missed.

4.27 Of concern was the use of the current use of the '5 Ps formulation'; the process consists of the following:

1. Presenting problem(s).
2. Predisposing factors which make the individual vulnerable to the problem.
3. Precipitating factors which trigger the problem.
4. Perpetuating factors such as mechanisms which keep a problem going or unintended consequences of an attempt to cope with the problem.
5. Protective factors.

4.28 Workshop participants reflected that the use of the '5 Ps' had largely replaced the taking of a full psychiatric history. The view was the '5 Ps' should be based upon a robust psychiatric history and should not replace it.

4.29 It was recognised that the taking of a psychiatric history was a more straight-forward process in inpatient and forensic settings (where there was a degree of continuity and a more consistent access to carers and Service Users). There was a clear sense that when people move between teams (and if those moves are reasonably frequent) there was a dilution of information as they 'moved through'. The difficulty presented by Service User movement was increased when there were cross-boundary issues. Patient continuity was seen as a major barrier to psychiatric history taking, diagnostic formulation and risk assessment. It was acknowledged that on frequent occasions Service Users were only with a particular service for a couple of weeks before being passed over to another team (and another consultant). This meant that the clinical record system needed to 'work harder' as it is a key foundation when ensuring continuity of care.

4.30 Workshop participants also recognised the difficulties in managing dual diagnoses. Dual diagnosis referrals are (on occasions) not being made to the substance misuse services and Service Users are not getting the support they need from CMHTs (referrals were not made due to the difficulty in getting Service Users accepted onto the specialist caseload). It was thought that some practitioners did not have the skills to manage Service Users with drug and alcohol problems (especially those who also had a forensic history). Suggestion to resolve: the Trust is already planning to pilot Dual Diagnosis Champions who will be embedded in teams. It was also considered that Forensic Outreach Teams could provide more specialist support to CMHTs to enable them to manage patients better. At the time of finalising this report the Trust stated this has now been achieved.

Summary

4.31 The findings from the documentary analysis were replicated during the course of the workshop held with Trust clinicians. The taking of a psychiatric history and the diagnostic process are important – they underpin the basic building blocks of care and treatment. Without a clear knowledge of a Service User errors can be perpetuated over time; this is a patient safety issue. Without a clear diagnostic framework to underpin care and treatment, inputs run the significant risk of not being either efficient or effective; this is of particular relevance when resources are limited.

4.32 The key factors identified were:

- deficits in psychiatric history taking;
- ineffective diagnostic and formulation processes;
- second opinions and appropriate referral to speciality services issues;
- continuity of care issues;
- inadequate record access and retrieval.

Clinical Risk Management

Findings from the Desktop Review of the Clinical Records

4.33 Examination of the five cases in the study identified the following:

1. There was no systematic approach to risk assessment. Risk assessments appear to have been few and far between (even when Service Users were displaying high risk behaviours and their presentation had altered significantly). Risk assessments did not usually synchronise with CPA reviews, care planning, safeguarding documentation, and the information contained in the day-to-day contact notes. Trust policy expectation was not met in relation to risk management.

2. Risk assessment information often appeared as a précised statement in the contact notes – however it was not clear where these statements were derived from or what the process had been to develop them. Significant risks were often recorded in the day-to-day contact notes – but were (seemingly) not subject to a formal assessment process or multidisciplinary discussion.

3. The practice of ‘cut and paste’ was evident. Risk assessment documentation was sparse – but in general robust risk assessments were recorded at the inception of the Service Users’ entry to mental health services. However these assessment documents were then re-used over the years (if assessments were recorded at all). The problem with this practice is that incorrect and out-of-date information was recorded and it was evident that the multidisciplinary team had not reviewed or re-assessed the Service Users in a dynamic manner.

4. Risk assessments rarely led to a risk mitigation plan; this aspect has been identified in previous CQC inspections at the Trust. Management plans could be as simplistic as a single sentence – made more problematic by the fact it was not addressing current presentation or risk issues.

5. Risk management was not proactive; the identification of relapse indicators and crisis planning were virtually absent across all five cases. This led to a reactive risk management stance being taken where service would intervene once a crisis had been reached rather than proactively managing risk and intervening before a state of total relapse occurred.

6. Consultant psychiatrists were sometimes involved in risk assessment processes (usually as a result of a CPA review and more likely than not in inpatient settings). However it was not possible to understand how consultant psychiatrists actually worked as part of the treating team to formulate risk.

7. Risk formulation (using the 5Ps) was ‘tick box’ and did not lead to a robust understanding of the Service User or the development of a mitigation plan. The process appears to have been formulaic and unhelpful. It also appears that formulation was often undertaken by nursing staff with no meaningful input from the multidisciplinary team.

8. The protection of children and vulnerable adults was of significant concern. It was apparent that there were consistent and significant child safeguarding issues for three of the Service Users in the study – there is virtually no documentation in relation to this – no assessment, no planning and no evidence of multi-agency liaison. This is not in keeping with Trust policy guidance. Adult vulnerability is sometimes ‘mentioned’ but neither assessed nor addressed.

9. Multi-agency working was difficult to understand due to the virtual absence of supporting documentation within the Trust record and through not having sight of other agency documents. It was evident that the Service Users in this study were open to several different agencies as well as Trust services. Three of the Service Users had significant, ongoing multi-agency inputs (MAPPA, Social Services etc.) – they presented with significant levels of risk and partnership working was most definitely indicated; it would appear this was not achieved.

10. Service User and carer involvement in risk assessment and planning was variable across the five cases. Both Service Users and their carers were invited to CPA reviews which sometimes discussed risk-related issues – however Service User and carer-reported concerns outside of CPA review were generally not considered. It appears that Service Users were told about risk assessment concerns – but did not directly contribute to the analysis; there is no evidence to suggest assessment documentation was shared with them. Of note was the lack of crisis and contingency planning – it was evident that carers did not know what to do in crisis or how to manage acute risk.

4.34 A key issue was the use of either the enhanced or standard risk assessment tool; this was dependent upon which service within the CMHT the Service User was open to. If the Service User was not open to the Complex Care Team (because they were undergoing a period of stability) then they were not assessed with the enhanced tool. It must be noted that the standard tool comprised a simplistic ‘tick box’ format which was not sophisticated enough to detect and mitigate ever-increasing levels of risk; this meant that the Service User usually slipped into crisis with elevated levels of risk before mental health services could provide a set of proactive interventions.

4.35 Policy guidance (e.g. CPA, Clinical Risk Management and Safeguarding) ‘were not joined up’ and neither were the documentation templates. This meant that assessments and resulting care planning had no synergy and practitioners needed to access data from entirely different fields on RiO (the electronic record keeping system) in order to access a complete set of information about a single Service User. In reality this meant assessment was not joined up and specific risks (in particular safeguarding) were not able to address issues in a cohesive and comprehensive manner.

Reflections from the Workshop

4.36 A key point of discussion was *"who does the risk assessment"*? It was recognised that a multi-disciplinary approach was more likely in an inpatient setting; however even when multi-disciplinary discussions took place risk assessments were not completed in 'real time' and were usually left to a lone individual to complete. This meant that the ultimate scrutiny of the whole team was missing; there was no process of sign off, endorsement, or quality review. Because there was no quality review the appropriateness and content of assessments were not monitored. It was also acknowledged that risk assessments and risk mitigation plans were not always connected. A *"sense of fear"* was described by some participants with regards to who signed risk assessment processes off as there was often the need to defend actions and decisions at Inquest. This led to further discussion about the need for risk assessment and management processes to be multi-disciplinary in nature with a formal sign off procedure.

4.37 It was identified that information from other services/agencies was not always incorporated. Trying to engage the Police, GP, and Social Services etc. was considered important but time consuming and not always possible.

4.38 Staff training was discussed. It was recognised that people needed to be trained and supervised – especially as less experienced, junior staff were often left to complete assessments and develop plans (this was also a findings of a Care Quality Commission 2019 inspection report).

4.39 The language used in risk assessment documentation was seen to be an issue. Whilst risk mitigation was possible, risk elimination was not – this needed to be formulated and noted. The wording in risk assessments needed more careful consideration – without the required levels of experience and skill it was more likely for *"defensive"* and/or *"bland*" statements about risk to be recorded. Also missing was the detailed weighing up of not only the risk of harm, but positive risk taking; it was thought that the Trust needed to provide more training and support in this area. If risk assessment and mitigation planning was left to more junior and less experienced staff (without the support of the whole Multidisciplinary Team) then overly concise and (at times unhelpful) documentation was more likely as staff were *"anxious about completing a fully honest risk assessment, and that's partly because they feel they might be criticised".*

4.40 Time limitations were also identified as being a key factor when producing overly concise risk assessments and plans.

4.41 The key factors identified:

- training, supervision and support;

- additional Trust guidance in relation to the ethos of risk assessment and mitigation;
- problems with multi-disciplinary working exacerbated by caseload pressures.

Summary

4.42 The Review Team recognises that some of the issues identified are also issues that affect every Trust in England; they are not just related to this specific Trust.

4.43 It was difficult to understand the risk management process from a review of the clinical records alone due to the overly concise nature of the notes. However what was apparent was that risk and diagnostic formulation were not conducted in keeping with either local or national policy guidance. This was evident in that the different strands of diagnoses and risk presentation were not brought together in a meaningful way in order to understand the levels of risk incurred; this was of particular note when considering psychosis side-by-side with complex and sustained substance and alcohol misuse (dual diagnoses).

4.44 The risk management process appears to have been ‘downgraded’ to a tick-box, formulaic process – often conducted by junior staff working in relative isolation. There was a disconnect between the contact notes and the risk assessments on file. Risk management (in reality) appears to have been a reactive response to the Service User’s presentation and/or reaching a point of crisis. Risk management planning was either non-existent or so superficial it could not provide proactive guidance for the Service User, the carer or the service in managing or mitigating risk.

4.45 A key concern was the lack of multi-agency risk assessment and planning (of particular relevance for those Service Users on license/MAPPA, and for those whose risk behaviours potentially put others – especially children at risk). Information sharing was virtually absent in the clinical records viewed. This lack of coordination and liaison made risk mitigation problematic for Service Users, carers and services alike. Another issue of note was that Service Users were constantly assessed by different teams and agencies (this can be detected in the clinical records as Service Users were often unable to keep appointments with the CMHT due to the pressure of other appointments and commitments). This took up a great deal of time and resource – it was also exhausting and frustrating for the Service Users; multi-agency activity did not always equate to meaningful engagement and appears to have been run in parallel rather than in synchronisation.

4.46 The key factors identified:

- a lack of multidisciplinary working;
- a lack of inter-service and multi-agency liaison and working;

- a lack of synergy between disparate Trust policies and assessment documentation;
- the lack of supervision, endorsement and sign-off of risk assessment documentation and process;
- the need for an overhaul of current systems and ethos;
- significant caseload pressures.

CPA, Care Planning and Care Coordination

Findings from the Desktop Review of the Clinical Records

4.47 Examination of the five cases in the study identified the following:

1. Service Users were often discharged from CPA when they still met the criteria. No explanation was provided in the clinical record – however it would seem that if Service Users had periods of stability (sometimes of a very short duration) they were discharged – this led to a cycle of crisis, re-referral and discharge on a repeat basis.

2. Assessment processes were weak (utilising a standard activities of daily living format which was often not appropriate); the consequent care plans did not address risk, were repeatedly ‘cut and paste’ and out-of-date. Care plans were often written in the first person (implying a Service User contribution) but this appears to have been a stylistic issue rather than a true representation of involvement – it is evident that Service Users were often not engaged, did not contribute to their plan, and did not take a copy of the care plan when offered.

3. Assessment and care planning did not appear to be multidisciplinary and did not include inputs from other Trust services or multi-agency partners. It was also evident that (once developed) CPA assessments and care plans were not routinely shared across other services and agencies. Crisis plans were virtually non-existent and when they did exist usually constituted a telephone number to call (usually in hours); there was no evidence to suggest they were shared with carers.

4. Mentions of safeguarding (child and adult), and other risk management information, were essentially absent in both the assessment and care planning documentation – this was not in keeping with the Trust’s ‘Think Family’ guidance.

5. Formal reviews of care appear to have occurred annually – but they were not also triggered by changes to presentation or crisis – reviews did not always appear to impact upon the care plans developed, and clustering procedures neither altered nor focused service provision.

6. Discharge was not always discussed with the Service User and the reasons given in the clinical records were not always clear – two of the Service Users were discharged due to disengagement/non-attendance

at meetings (this is specifically not in keeping with Trust policy guidance).

7. Service User inputs to the CPA process seemed to be somewhat tokenistic and when disagreements occurred the CPA/care planning process went unaltered. Service User choices were minimal and a strict and overly boundaried approach was often taken. Carers were usually invited to formal CPA Reviews – but were unable to input in a meaningful way outside of these meetings (even when a crisis was looming).

8. Despite the issues detailed above there is evidence to suggest care coordinators worked hard, followed their patients up in the community, and made every attempt to coordinate care. However it was also evident that they worked as community-based professionals rather than coordinators of care.

4.48 The focus of the treating teams was on managing crisis or acute presentations. Once 'recovered' Service Users were usually discharged from CPA (and usually from all community-based services). The focus was not on ongoing recovery and wellbeing – the five Service Users in this study had all become unwell at a relatively early stage in their lives – this meant that as troubled adults they had few coping skills and often had significant ongoing needs – CPA/community services did not recognise or meet these needs; this probably made a contribution to the repeat cycle of relapse that occurred.

Reflections from the Workshop

4.49 CPA reviews/MDT meetings were often not attended by key professionals as people *"are pulled from pillar to post".* The consensus was that job planning would be supportive and enable people to manage service expectations better. Care coordinators (and CMHT's in general) are overwhelmed by the size of caseloads (exacerbated by Covid) and the risks teams are carrying. They are focused on ticking boxes and getting deskilled in using *"clinical common sense".* Suggestions to resolve: more training and support is required to manage complexity; but this would also require additional resources to reduce caseload numbers. Reduction in the numbers of teams was considered sensible as the 'hand-offs' take time and patients *"fall down the cracks".*

4.50 A key reflection of the workshop participants was that safeguarding was not addressed appropriately – especially in relation to children; a particular recognition was that the grandchildren of older patients were not considered and they should be. There was a recognition that safeguarding requirements needed to be made more explicit in order for CPA to be effective.

4.51 The CMHT/CPA/Safeguarding interface was described as *"clunky"* and this was regarded as being the main reason why the 'Think Family

Approach' (in relation to child welfare and safeguarding) was not embedded – this was an issue that had already been identified via the Trust's own thematic review process.

4.52 Workshop participants admitted to a 'cut and paste' approach in relation to care planning (knowing this would probably avoid detection during audit as long as something was written).

4.53 Services and agencies have access to different recording systems. There is an inconsistency in cross-team/agency access; this inconsistency was deemed to *"cause risk".* Workshop participants asked whether they could (as a minimum) have read-only access to: EMIS; LAS; RiO; CiTO, Windip; LPRES; ECR; and IAPTUS.

4.54 In relation to care coordination workshop participants discussed the national changes to the Care Programme Approach (CPA).[1] Care coordinators will be replaced by key workers – it was uncertain how the changes would support staff experiencing burn-out and tiredness which resulted in them not updating risk assessments and care plans. It was discussed that the Trust suite of templates possibly made a contribution to an overly concise record being developed as staff were *"reluctant to stray"* from templates as it helped them *"get the job done"*; it was recognised that this approach did not support patient-centred care.

4.55 The interface between CMHTs and Forensic Services was discussed in relation to CPA; it was agreed that *"there's no one way of everybody who needs information getting hold of it"*; this was due to the incompatibility of different record systems. It was also understood that the threshold for referring to forensic services (and dual diagnoses services) was high and that there was an expectation that CMHTs should *"manage".* CMHT services were stretched with *"big caseloads, lots of complex patients on those caseloads".* Care coordinators are expected to *"to do"* everything and often work in isolation. This was a key factor in care coordinators not having enough time to:

> *"… keep up on top of all that paperwork, and also we were talking about lack of time in reading notes before going to a CPA review. It was mentioned that staff can also often join that meeting blindly. Having not read everything beforehand because they simply don't have the time to do that, which obviously affects the quality of that meeting and what could be the outcomes of that. So we were just talking about how we can manage that better and there's a suggestion for a need for job planning, just to ensure that staff do get that dedicated time".*

4.56 A key reflection was that due to pressures on specialist services (e.g. forensics and dual diagnoses) care coordinators and CMHTs were

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[1] Care Programme Approach NHS England and NHS Improvement position statement 1 July 2021 Version 1.0

expected to manage a level of complexity that they did not know how to deal with. Service User caseloads held high amounts of risk and this caused a great deal of stress to practitioners. It was mentioned:

> *"I think that's where the process can slip up a little bit, because it just comes down to one person. We are human beings, we make mistakes and if it is just on one person to fill in all that paperwork when you've got caseloads of 30, plus duty tasks, plus any complaints to investigate or whatever else that you do, something is going to go wrong. And unless that changes I think things are going to continue to happen, and I think the job planning thing was music to me".*

Summary

4.57 The findings from the documentary review of the clinical records were made more meaningful by the workshop inputs. Workshop participants did not dispute the main issues identified by the documentary analysis. The workshop contributions were able to highlight three main issues which might be compromising the effectiveness of CPA:

1. Caseload overload leading to professional burnout.
2. The need for work plans and protected time.
3. Incompatible and inaccessible record systems.

4.58 From an examination of the five cases the Review Team could see that on occasions individual practitioners were identified as failing to adhere to Trust policy guidance and remedial actions focused on these individuals. The Trust also recognises (via its own thematic review processes) that CPA and Care Coordination sometimes does not meet policy expectations in general. The Standards Proforma audit process has yielded a general non-compliance with key aspects on policy guidance across all of the cases and across a number of years and is systemic. The workshop discussion focused on some of the underlying reasons why.

4.59 Caseload overwhelm and resource restrictions appear to be making a significant contribution to:

- early discharge from CPA;
- complex cases being 'held' by CMHTS due to a lack of caseload capacity with other services (e.g. forensics and dual diagnosis);
- a lack of true multidisciplinary working due to time constraints and competing priorities;
- problems with professionals having no time to contribute to joint assessment and planning meetings;
- time restrictions which make a contribution to records being inadequately accessed, developed and shared.

Managing Disengagement

Findings from the Desktop Review of the Clinical Records

4.60 Examination of the five cases in the study identified the following:

1. Service Users referred for care coordination were sometimes left without follow up (due to the disengagement of the Service User). It was noted that often the approach taken by mental health services was not assertive enough given the known level of risk and sometimes discharge took place before allocation/assessment occurred.

2. When Service Users disengaged teams would arrange for routine follow up – however follow-up was found to be inconsistent over the years and was often dependent on the determination of individual practioners. The main issue identified was the relative lack of recorded relapse signatures. When relapse signatures were recorded disengagement was usually recognised as a symptom of worsening mental health and increased paranoia. However the reasons for disengagement were neither understood nor explored. In some instances long periods of disengagement would occur leading to total relapse before any action was taken. It is of note that no care plans were developed (in keeping with Trust policy guidance) to manage disengagement for those individuals known to have this tendency.

3. Disengagement (together with a general lack of cooperation) was sometimes seen as a ‘prompt’ for discharge. This practice went against Trust policy guidance. The decision to discharge was usually made either at CPA review or multidisciplinary meetings – however Service Users were not involved in this decision making and risk assessments were not conducted to ascertain the degree of ongoing mental illness and the level of risk posed. This was a finding of particular note with those Service Users diagnosed with Personality Disorder.

4. Trust policy guidance requires special consideration to be given to the families of Service Users who disengage when there are dependent children involved. This was not achieved.

5. Trust policy guidance requires that teams consult with GPs, carers and other relevant third parties when Service Users disengage. It was evident that this did not happen.

4.61 The Review Team found the Trust engagement policy to be an exemplar of best practice; the issue, however, is whether it is achievable. How feasible it is to liaise with the GP and Social Services (for example) every time a Service User disengages? How responsive will these other services be? What exactly is the Trust trying to achieve by doing this? What does the Trust actually expect of these other services? The policy might be a bit over optimistic and it is evident many of the actions advised are not, and sometimes cannot, be put into practice.

4.62 The Trust's Promoting Engagement and Access to Mental Health Services Standard Operating Procedure (March 2021 – March 2022) suggests the use of assertive outreach – but in reality this is not a uniform provision across the whole Trust – the expectation is unrealistic. In reality assertive outreach teams were disbanded some 10 years ago and CMHTs have to add this function into its day-to-day working.

Reflections from the Workshop

4.63 It was recognised that the level of effort required to engage Service Users depended upon the amount of 'leverage' the teams had at their disposal. For instance forensic services could ensure engagement because of Court and Probation involvement. In the main there was felt to be a tension between managing risk and ensuring engagement – this was felt to be difficult – especially when more than one team was involved.

4.64 There was a sense that the responsibility to engage did not rest with clinical teams alone and that Service Users needed to share responsibility, especially if they had a Personality Disorder (PD); it was thought this type of diagnosis conferred an additional layer of accountability to the Service User. It was understood that Service Users with PD were sometimes discharged if it was thought to be *"the only option"* – however there was some unease about this. It was also thought that the role of mental health services needed to be defined when Service Users persistently disengaged and refused to comply with care and treatment. This was seen as being of relevance due to caseload overload and restrictions on the resource available. Workshop participants discussed the need for a more honest communication with Service Users, referrers and commissioners, setting out the practical limits to what a service can achieve because sheer willpower and intense follow up could not always ensure an independent third party (the Service User) cooperated. There was a feeling that mental health services were expected to *"fix"* everything when in reality they could not.

4.65 This theme was considered further in relation to initial GP referrals when mental health teams found it impossible to make contact with the Service User in order to assess them and allocate an appropriate team. The dilemma faced by service was explored and the lack of 'leverage' was recognised as a key problem – mental health teams could not enforce engagement and often felt like their *"hands were tied".*

4.66 It was noted that specialist assertive outreach Teams had been disbanded ten years previously. However Trust policy guidance still mentioned referral to assertive outreach when in reality this service no longer existed – instead it was yet another adjunct to already overloaded CMHTs. This was an area that workshop participants felt had not been sufficiently thought through by the Trust.

4.67 The key factors identified:

- large caseloads hindered care coordinator efforts to maintain contact;
- there is a tendency to discharge Service Users with Personality Disorder (described as *"uncooperative patients")* – teams often do not have the time to reflect on what steps could be taken to prompt further engagement;
- Home Treatment Teams sometimes feel stuck in the middle when people do not engage;
- some treating teams finish their working day at 5pm, which is sometimes not helpful in engaging Service Users and liaising with referrers;
- caseload sizes reduce the flow between teams;
- more support is needed to facilitate engagement;
- the Trust should undertake a review of who is discharged (and why) in order to understand if decisions are taken appropriately;
- mental health services need to be honest and transparent about what they can achieve and what they cannot (with Service Users, commissioners and referrers alike);
- better partnerships need to be built with referrers;
- mandate reflection time for teams together with individual thematic analysis.

Summary

4.68 The Review Team found that many care coordinators worked hard to follow-up Service Users who disengaged. However this activity took place outside of a systematic framework – Trust policy guidance was not followed and no coherent strategies were deployed. It is evident that in general, the majority of Service Users (those to whom Community Treatment Orders do not apply) are independent 'third parties' who can choose whether they engage or not. The Review Team understands the difficulties. However clinical teams should follow best practice guidance in the first instance (e.g. identifying relapse signatures, building a therapeutic relationship, developing disengagement care plans) before taking the decision to discharge patients from service.

4.69 The workshop participants identified several useful issues that hindered best practice from taking place – amongst them caseload overload, a lack of team reflection and service audit. Workshop participants also identified the need to be honest with Service Users and referrers about what realistically can be achieved. The Review Team is in agreement, but would draw the Trust's attention in the first instance to the basic building blocks of care as outlined in paragraph 4.68 above; these should be addressed, and every effort made to engage with Service Users utilising what is nationally recognised as being evidence-based, effective methods.

4.70 Of concern was the ongoing practice described by the workshop participants of discharging Service Users with Personality Disorder who disengage; the implication being that a higher level of personal responsibility can be assigned to them. Whilst the Review Team recognises the rationale behind this – it is not keeping with the National Institute for Mental Health in England publication *Personality Disorder: No Longer a Diagnosis of Exclusion* (2003) or the changes made to the Mental Health Act in 2007. Personality Disorder was part of the diagnostic picture for two of the Services Users in this study – it was evident that their occasional disengagement and non-compliance triggered an (at times) overly boundaried response which led to discharge. This approach did not take into account differential diagnoses and dual diagnoses – these individuals posed exceptionally high levels of known risk and should have been managed differently. The Trust will need to reconsider the approach currently taken with Service Users diagnosed with Personality Disorder – together with the accessibility and effectiveness of its Personality Disorder pathway.

Carer Assessment and Involvement

Findings from the Desktop Review of the Clinical Records

4.71 The 2020/2021 Annual General Meeting report describes the Trust's commitment to the 'Triangle of Care'. The report states that The Trust has completed Phase 1 of the Triangle of Care (ToC) and was awarded a star in July 2019 for its carer inclusive and supportive commitment. The ToC is a therapeutic partnership (between carers, people who use mental health services, and professionals) based on engagement, information sharing and support. It aims to promote safety, recovery and to sustain wellbeing in mental health by including and supporting carers.

4.72 Examination of the five cases in the study identified the following:

1. Service Users were sometimes asked to identify carers at the inception of their care and treatment with the Trust; however this was not always achieved (or recorded). For those individuals who were identified as being the main carer there was a virtual absence of carer assessments mentioned on file. In one case it was evident that the carer was offered an assessment – but the therapeutic relationship had broken down and the offer was declined (this might have been prevented had an earlier opportunity to carry out a carer assessment been achieved). In another case a carer assessment was offered – but there is only a single blank assessment document on file; in the event the carer had to leave the home shared with the Service User due to safety concerns and a lack of general support.

2. When carers were involved they were usually invited to attend CPA reviews and were able to contribute to the discussions held. However if a carer made contact with mental health services to express day-to-day concerns (non-compliance with medication, excessive consumption of alcohol, worsening of psychotic symptoms etc.) they

were not always responded to with either a helpful or timely response. Most carers raising concerns were either ‘fobbed off’ (e.g. asked to go and assess the problem themselves, or call the Police) on most occasions they were asked to wait until the next CPA review or outpatient appointment. This often led to a worsening of symptoms and (on occasions) a total relapse. Treating teams usually refused to engage with carers over the telephone if the Service User had withheld consent for their inclusion; staff did not recognise that they could listen to the concerns being raised (and also act upon them); they did not have to impart any information and so patient confidentiality would not have been breached.

3. There is little evidence on file to suggest carers had access to copies of risk assessments and care plans. This was of particular note in relation to crisis and contingency plans (where they existed). It was evident that carers did not know what to do in crisis or who to contact. They were often left to signpost themselves and call the Police or take the Service User to A&E.

4. Carers were sometimes contacted in relation to disengagement – however this practice was not consistent.

4.73 The Review Team found the main issue was not so much how services communicated with families and carers in formal settings (such as CPA reviews) but how they responded to the day-to-day concerns raised by them when Service Users were relapsing. Carer concerns were not always addressed in a timely manner – and neither were they always addressed with the carers’ ongoing wellbeing, safety and support in mind. This was exacerbated by the virtual absence of consideration given to carer assessment and support planning.

Reflections from the Workshop

4.74 Workshop participants agreed that some teams within the organisation worked well with carers. Examples of good practice could be identified when Service Users gave their consent at the outset for carers to be involved – however it was recognised that *“that it's much harder when the patient has capacity and they say they don't want the carer involved, and then something goes wrong”.*

4.75 Clinical staff were often uncertain how to work with carers, but were aware they could listen to information offered – even if they could not divulge information when Service User consent was withheld (The Review Team could only find partial evidence to support this view).

4.76 Capacity to withhold consent was only assessed sporadically and there was some reluctance for staff to record the decisions taken. The Trust acknowledged that this was a common theme with complaints received. Workshop participants were of the view that Service Users were not *“regularly asked who they want to be involved in their care”.* A key reflection was that there was no *"tab"* in RiO to record consent in relation to information sharing – so the information (if it was recorded) might be *"buried… because it's always difficult to get to certain parts of Rio"*.

4.77 It was recognised that where significant risks were present (such as safeguarding children or a known risk to family members) the Trust needed to do more to ensure carers were worked with and that information needed to be shared (with or without consent). However it was also recognised that this was a challenging issue as no one wanted to breach patient confidentiality or to potentially disrupt a therapeutic relationship with the Service User.

4.78 Workshop participants agreed that realistic boundaries needed to be set with Service Users at the outset, and that staff needed to be more honest about when confidentially would be breached and information shared with carers. Where risk was present staff were aware that disclosing information could heighten those levels of risk and a carefully contracted approach was needed.

Summary

4.79 It is important to understand that the potential tension between Service User confidentiality and carer involvement has been recognised nationally for decades. It has long been understood that carers should always be encouraged to share significant information and should always be informed if they are at potential risk – whether the Service User wishes this or not. The level of uncertainty expressed during the workshop (combined with the evidence from the documentary review of the clinical records) suggests that more staff training and refocusing needs to be done. Trust policy and procedures advocate carer involvement – but it is evident that there is a disparity between what is stated in the policies and what staff feel both empowered and enabled to do.

Access to Service, Resource, Referral and Waiting Times

Findings from the Desktop Review of the Clinical Records

4.80 Examination of the five cases in the study identified the following:

1. It was difficult to assess whether or not duty workers ensured all relevant information about referrals was recorded, and liaison with both referrers and services making transfers took place; this was due to the relative lack of documentation to make a valid assessment. However, based on what was available, the quality of the process appears to have been variable – liaison communication was brief and referral documentation was often incomplete with many fields on the forms left blank.

2. The ease of primary care service referral for more specialist input was problematic. It was not always certain which CMHT service a person should be referred to. There were often delays in assessment and allocation.

   On two occasions a Service User (who was psychotic and presenting with elevated levels of risk) was referred by the GP but discharged due to non-attendance. The GP had expressed significant concerns about the Service User – but there was no liaison between the Trust and the GP practice to decide what course of action should be taken.

3. On referral Service Users were usually contacted by telephone and/or letter as required by the Trust's policy guidance. However on occasions this approach was not enough to ensure assessment took place. Service Users (with a prior history with Trust services) who were psychotic (and who had a relapse signature of non-engagement) were not always followed up assertively enough. This sometimes led to them being discharged before they had even been seen. Consequently a total breakdown of their mental health occurred. It was noted that referral processes appeared to have been managed more effectively before 2017.

4. Decisions to remove Service Users from a waiting list were not always made following a contemporaneous risk assessment. It was noted that risk assessments (if they existed) were often out-of-date and cut and pasted from earlier documents.

5. Service Users were observed to be discharged following very short periods of stability. It should be noted that the five Service Users in this study were all identified as having severe and enduring mental health illnesses/disorders. It seemed to be counter productive to discharge after such short and untested periods of stability. The Review Team considered 'recovery' to be a cyclical process, not a linear one; periods of wellness and relapse can be life-long features. Levels of input focused on acute presentation, discharge and re-referral during relapse. This is not a recovery model.

4.81 There was a limit to what the Review Team could ascertain from the five cases in the study. However it was possible to understand that referrals for dual diagnoses and forensic services were not routinely made; even after significant problems had been identified.

4.82 A seeming 'gap' in provision was that of recovery service inputs. The Review Team understands that there is a Recovery Team; however inputs from this team did not appear to be integrated within mainstream CMHT services. It was evident that all five Service Users in this study had experienced mental health problems from a relatively young age; three of them had either been in prison or in care (one individual had been in both). This meant that their day-to-day functioning and activities of daily living were poor; more support was needed (e.g. managing finances, healthy eating, cooking, maintaining wellness etc.). Whilst care planning focused on the assessment of activities of daily living this did not lead to supportive care plans.

Reflections from the Workshop

4.83 Workshop participants described specific difficulties when trying to refer to dual diagnoses and forensic services; Service Users were often unable to access these specialist services (primarily due to resourcing issues). Consequently CMHTs have to try to work with Service Users without the necessary skills and experience to support them fully.

4.84 In keeping with the themes already examined above, significant caseload pressures were identified as a key factor leading to decisions to discharge Service Users when they perhaps required ongoing monitoring and support.

4.85 Workshop participants considered the current CMHT service model had too many ‘separate’ teams’ within it. This model did not provide a patient-centered approach, put care and treatment options into silos, and increased both workload and risk when Service Users were passed from one service to another. Workshop participants considered that a more integrated CMHT model would be more efficient and also more effective. This would mean that a person could access both Complex Care and Recovery services at the same time.

Summary

4.86 Mental health services appear to be under a great deal of pressure. Once accepted onto the caseload Service Users move through a pathway which segments CMHT teams – this is labour intensive and not always patient-centered. During periods of recovery Service Users are often discharged to primary care without the necessary levels of ongoing support being offered.

4.87 It would be unrealistic to set recommendations that call for more resource to be made available – however there appears to be a great deal of manoeuvre for change and improvement within current resource envelopes by re-working the current CMHT service model.

Multi-Agency Working

Findings from the Desktop Review of the Clinical Records

4.88 Examination of the five cases in the study identified the following:

1. Several of the Service Users in the study were open to more than one multi-agency partner at any one time. Of particular note were three

Service Users who presented with significant and ongoing-levels of risk. They were subject to MAPPA, Probation, Social Services, and the Youth Offending Team (in one case). One of the Service Users not only presented with high levels of risk to others but had also been the subject of significant sexual abuse and was open to child protection services. Another Service User was noted to have three different care coordinators from three different agencies all working with him at the same time; it was evident they were not working in partnership.

Despite significant evidence of multi-agency involvement, documentation pertinent to the ongoing care, treatment, safety and wellbeing of the Service Users (and the general public) was largely absent on Trust-held systems. It was also evident that Trust-based services did not have read only access to multi-agency partner systems.

2. There were some basic examples of risk assessments and care plans being shared across agencies – but this was usually at the beginning of the Service User pathway and was not sustained over time. It was evident that whilst basic documentation was shared on limited occasions, the actual assessment and planning processes were undertaken in parallel, rather than as a joint enterprise. This meant there was a significant duplication of effort, a lack of partnership working, and a somewhat confused series of inputs and interventions (for the Service Users) from a multitude of different services.

   The main difficulty with this lack of join-up was that identified risks were neither communicated freely between agencies nor managed effectively.

4.89 The Review Team found that multi-agency working was run in parallel most of the time. It remains unclear how policies and protocols for joint working are both developed and implemented. There was little evidence to support the notion that the Service User was at the centre of all of the activity; neither was it possible to understand the actual benefits and effectiveness of the multi-agency inputs.

Reflections from the Workshop

4.90 Workshop participants identified several issues in relation to multi-agency working. The first issue was the relationship between Trust services and those of substance misuse services. It was acknowledged that the relationship with substance misuse services needed strengthening. There was reluctance from some Trust-based professionals to refer patients to the service – the culture in the Trust remains that Service Users should ‘self-refer’ even when their mental health is precarious and they not fit to do so.

4.91 It was identified that there was an ongoing issue with one of the local Councils in terms of multi-agency working and continuity of care; this was because there is no information sharing agreement in place (and therefore) information does not follow the patient. This was not a new problem – but the absence of an information sharing agreement with the Council meant there was no continuity of care when Service Users moved from locality to locality (as they frequently do). This was regarded as a major barrier to professional communication and joint working.

4.92 Workshop participants from forensic services were of the view that interagency working with Probation and Social Services was improving but was still *“not good enough”.* The MAPPA process as it currently stands (on the ground) requires inputs from forensic services. However when Service Users move through to other services (particularly to CMHTs) MAPPA information cannot be accessed. The ongoing communication process depends on the quality of handovers and regular professional liaison. This is not always achieved. Forensic out-reach services work across locality teams and find it difficult as teams are given different names and functions – they did not always know if they were referring to *“the right team with right function”*. It was acknowledged that if it was confusing for a Trust-based service, then it must be difficult for multi-agency partners to know how different teams within the Trust operate.

4.93 Getting professionals from representative agencies to contribute to Trust-based assessment and planning can be a *“big problem”.* There are often problems with accessing information as the information sharing agreements across different agencies are not aligned. There are also problems when trying to access clinical records from out of area services. These difficulties have been exacerbated by Local Authorities Adult Services which were withdrawn from integrated Trust-based provision. Social workers are no longer embedded in the CMHTs; they only have limited access to RiO, and there is lack of continuity of input. This leads to ‘uncoordinated care’; for example – CMHTs do not know when the social worker last visited and have no access to the social worker records. Neither was there a Trust-based understanding of how social workers were allocated to cases. The move to localities appears to have strengthened links with local partners; however there was an observation that some of the strategic overview has been lost that had existed through the old Mental Health Networks.

4.94 It was noted that care coordinators had to spend a *“significant chunk”* of their time liaising with multi-agency partners trying to get professionals together and to access information across teams. It was thought by some workshop participants that more administrative support roles were needed to facilitate these processes.

4.95 Up-coming changes to the CPA process and the change from care coordination to key working were recognised as having a potential impact on multi-agency working. Whilst the existing operational links within localities were deemed to be strong there were concerns that there were some strategic links that might be missing.

4.96 Since the changes in the way social workers support Service Users (since their withdrawal from Trust teams) it was felt that patients are not being referred for social care assessments and not getting the support they need; it was also noted that carers are missing out on carer assessments. A solution to this was to have an *“early trigger prompt”* on RiO to ensure referrals were made and followed-up.

Summary

4.97 The lack of multi-agency partnership working was a key feature of the cases under review; with particular reference to Social Services and Probation. Despite intense levels of input from several different agencies at the same time. There was little joint working (e.g. risk assessments, information sharing, care planning) that put the Service User at the centre of the activity. It was also evident that shared access to information was problematic and that assessment, monitoring and planning took place in parallel.

4.98 Both the Trust and the commissioners of this Review had already identified multi-agency working to be a key theme of concern. On a closer examination (with the support of the Trust workshop participants) it is apparent that there are several factors working together to hinder partnership working; these factors are as follows:

- IT systems that cannot be accessed by the different services and agencies;
- a lack of synergy between the disparate policies and protocols of each service/agency (in particular those pertaining to information sharing);
- a culture where services and agencies do not automatically come together;
- significant caseload pressures which have a negative impact on professional communication and liaison.

4.99 On a positive note, a multi-agency forum now meets on a regular basis across the locality; its purpose is to promote better interagency working. The Review Team was able to feedback key interim findings from this Review.

Adherence to Policy and Procedure (local and national best practice)

Findings from the Desktop Review of the Clinical Records

4.100 Examination of the five cases in the study identified the following:

1. The Thematic Pathway Review Proforma is a quality standards audit tool. The proforma identified a consistent lack of policy and procedure adherence over a number of years (of note between 2015 and end of 2020). Non-adherence issues do not appear to have been caused by

COVID challenges (these problems pre-existed COVID) – but they might have been further exacerbated by them.

2. Based on the findings, the Review Team is of the view that current Trust audit processes are not sensitive enough to detect the breadth and depth of non-adherence. This is to be expected when ‘snapshot’ audits are undertaken which do not take into account a longitudinal view of clinical records (things like ‘cut and paste’ practice can be missed and a false assurance given).

3. The Review Team understands that there are significant caseload/workload pressures within community-based teams. We heard that practitioners often take short-cuts in order to save time, that supervision, multidisciplinary sign off and endorsement often does not occur, and that relatively junior staff are becoming de-skilled in relation to what they need to do.

Reflections from the Workshop

4.101 Issues relating to the non-adherence of policy and procedure had been identified by the thematic review processes undertaken by the Trust in 2020.

4.102 Workshop participants described a workforce under significant pressure. This pressure led to short cuts and also a decrease in ‘real time’ supervision and support for more junior and less experienced staff. Workshop participants voiced the view that most practitioners understood how audit worked and also knew how to ‘work around it’ to avoid poor practice being detected.

Summary

4.103 The Review Team recognises that it is relatively rare for such a detailed-level of audit (such as this Review) to be undertaken; it is likely that if replicated across other Trusts in England similar findings would be found. That being said – the Trust has recently implemented ward accreditation and monthly inpatient safety metrics audits for inpatients. Community safety metrics audits are being implemented for community teams, which have been piloted. This is currently a monthly peer review of standards and practice in the community which will supplement the Trust’s clinical audit programme.

Safeguarding

Findings from the Desktop Review of the Clinical Records

4.104 Examination of the five Cases in the study identified the following:

Children:

1. There are two mentions in the clinical records examined by the Review Team of child safeguarding concerns/referrals; however it was not possible track how the referrals were managed or what the outcomes were.

2. Examination of the clinical records show that the needs of children (who had regular contact with mental health Service Users) were not routinely assessed. It was evident that the needs, safety and wellbeing of children were not a primary focus (despite the Trust's 'Think Family Approach'. Of concern, key factors (like parental/family psychoses, aggression and substance misuse) did not trigger child-centered assessment, care planning or multi-agency consideration.

3. The levels of risk posed to children were often 'left up' to the Service User to determine; this went against Trust policy guidance. There is no evidence to suggest objective third party information was sought to validate the views of the Service User. It is of note that children were often identified as being 'protective factors' but there was no consideration as to the wellbeing and safety of the children concerned. There was no evidence to suggest non-compliance with treatment, substance misuse, or psychosis was an automatic trigger for child safeguarding processes and/or referrals on to Social Services (as indicated in Trust policy guidance – see the Standards Proforma).

4. There were no assessments made at key points on the pathway, or when changes to the Service Users' circumstances or presentation occurred (e.g. resumption of contact with children, relapse, and discharge). Child safeguarding was not integral to the ongoing assessment process.

5. CPA rarely mentioned children; although historic out-of-date data was often provided within the opening narrative preamble (usually as a result of regular 'cut and paste' practice). Known levels of risk (violence, assault etc.) did not prompt assessment or review. Three of the Service Users had either MAPPA or YOT involvement combined with histories of significant violent assault. There appears to have been little join-up in relation to the safety and wellbeing of children recorded in the clinical record.

Vulnerable Adults

6. All five of the Service Users in the review were described as 'vulnerable adults' at some stage during their time with the Trust. There were also key markers for neglect present (e.g. self-neglect, weight loss due to not eating, poor day-to-day functioning, confused and problematic lifestyles). Despite this there were no capacity assessments to support service interventions and decision taking. In one case there were examples of good practice where information relating to vulnerability was drawn from several sources – but it was

not possible to understand how this information was used and how it impacted positively upon care and treatment. The words ‘vulnerable’ and ‘vulnerable adult’ are used frequently in the clinical record – however it is not clear what is meant. It is never clarified whether or not a capacity assessment had been conducted and whether the words ‘Vulnerable Adult’ are used in keeping with the Mental Capacity Act (2007).

7. Risk assessments, CPA reviews and discharge planning neither addressed nor assessed vulnerability (although Trust policy guidance requires this). Instead a ‘tick box’ process was deployed which did not get underneath the ongoing issues that persisted.

8. Whilst none of the Service Users in this study had carers or other family members who could be deemed to be vulnerable in keeping with the Mental Capacity Act (2007) definitions, it was evident that they were often at risk. Levels of risk to carers and family members were also not assessed.

4.105 The requirements of the Trust’s safeguarding and CPA policies are not specifically outlined in the Trust risk assessment policy and assessment documentation; this appears to foster a somewhat cursory assessment in relation to safeguarding. The basic risk assessment and safeguarding assessment tools are ‘tick box’ in format and do not appear to support a full narrative analysis. The Review Team noted that relevant policies and documentation are not linked together; this has the effect of facilitating omissions in assessment as the necessary prompts and synergy are not there.

Reflections from the Workshop

4.106 The consensus of the workshop participants was that each team should have a safeguarding champion; the purpose being to embed safeguarding in day-to-day practice. This would also prevent the intense workload of the duty safeguarding practitioners who were *“getting up to 40 calls a day so dealing with significant volume, which is why they want to invent the safeguarding champion role more”.* It was also noted that the Trust has significantly bolstered its safeguarding training since the time of the case studies included in this review.

4.107 RiO and Trust assessment templates were discussed. ‘Liquid Logic’ has a relationship tab so matches and links can be made with families and Services Users; but this was not possible on RiO. It was noted that the safeguarding children form was *“less visible”* on RiO and that there was a *“feeling”* that child safeguarding assessment forms were not routinely filled in as the standard risk assessment template had no specific mention of children on it. If children were not mentioned on the template then any omissions in child safeguarding assessment would not be detected during template compliance audits (as there was nothing to audit). A concern was expressed about creating yet more paperwork and it was thought that child safeguarding should be made more explicit in existing documentation (risk assessment, CPA etc) and Trust policy aligned accordingly. If child safeguarding documentation remained separate then there was a feeling that it would never be integrated into mainstream thinking and assessment.

4.108 It was recognised that the quality of assessment and content of the clinical record relied upon the competence, experience and curiosity of the clinicians involved. It was felt the Trust needed to focus more on wellbeing (school attendance, age appropriate toys in the home etc.) not just risk and the categories of abuse. Clinicians needed to have full discussions with families rather than ask questions by *“rote”*; in order for a more well-rounded approach to be taken additional training was indicated.

4.109 The incompatibility of electronic patient recording systems (and lack of general professional communication processes) also needed consideration. It was recognised that Service Users and their families were often involved with a multitude of other services/agencies but that there was no method by which Trust practioners could access information (or provide it) on a central system.

4.110 The key factors identified:

- good support from safeguarding practitioners and safeguarding supervision were in place but would be supported further by safeguarding champions – this would strengthen frontline expertise and access;
- communication between different services/agencies is challenging;
- electronic databases do not lend themselves to good safeguarding practice;
- Trust assessment templates (risk, CPA, safeguarding) need to be integrated to ensure seamless child-centred processes;
- There is a need to link incident reports to risk assessments which will require updating;
- it is important to highlight whose continued responsibility safeguarding is (and at what point) particularly when patients transfer between community mental health teams;
- confidence of practitioners is sometimes lacking (not always knowing what to document and assess including those outside of the Trust e.g. GPs);
- safeguarding training needs to include some of practical aspects e.g. what to document (such as) age appropriate toys in the home, attendance at school etc. rather than ‘ticking’ categories of abuse;
- lots of services link in but there is no central recording system;
- safeguarding should be built into the culture of teams and services so it is seen as everyone’s business;
- the culture of communication needs to change – there are too many emails which are impersonal and just seems to offload problems rather than deal with them;

- there is not enough experience on the ground dealing with high risk patients – there is a need for more Band 7 practitioners engaged directly with Service Users;
- sometimes patients have to engage with many teams – perhaps there needs to be a single team focused around a child-centered model.

Summary

4.111 It was of note that Workshop attendees focused on the issues relating to child safeguarding; those issues relating to vulnerable adults were not considered during the time available. However there are common denominators for both child and adult safeguarding.

4.112 Policies and paperwork are not joined up; at best this could lead to duplication and at worst omissions. Some documentation does not lend itself to meaningful assessment – instead a series of closed questions are provided with 'tick boxes' for completion. The risk management, CPA and safeguarding paperwork does not link, and neither do the supporting policies.

4.113 As has already been said, the insights provided by the workshop participants in relation to children are also pertinent for vulnerable adults; in particular:

- the benefits of safeguarding champions;
- a review of policy guidance and assessment documentation;
- electronic databases (particularly those held by multi-agency partners) should be redesigned as a central access system (in relation to safeguarding);
- where consistent safeguarding issues are present, children and vulnerable adults should be supported by a ''single' or 'main' team.

Escalation Pathways and Access to Mental Health Services

Findings from the Desktop Review of the Clinical Records

4.114 Examination of the five Cases in the study identified the following:

1. There was a degree of variability across the different Service Users in the study and the services they received. However the majority of the care and treatment described in the clinical records revolved around medication and general monitoring. The focus was not on recovery and discharge from service took place frequently when a period of stability was reached (even if it was of relatively short-standing and was untested). This meant that Service Users often relapsed requiring either referral back to the CMHT or to an inpatient setting; often in a state of crisis. Access back into service (and particularly access to

inpatient care) was usually achieved – however there was often a delay of several days during which time the situation worsened.

2. For those Service Users in crisis (already on the CMHT caseload) there sometimes appeared to be an element of confusion as to how to proceed – probably exacerbated by there being a virtual absence of relapse and contingency planning. It was also evident that carers did not know how to access support during relapse and crisis. Carers were often asked to use A&E or contact the Police; this was not good practice. The sporadic identification of relapse signatures and the virtual absence of crisis plans meant that a steady deterioration in mental health often went unnoticed until a full blown crisis was in play.

3. Two of the Service Users had complex presentations combined with a degree of diagnostic ambiguity. They were kept within CMHT services even though this service 'was not enough'. Both had been diagnosed with Personality Disorders and psychosis together with significant substance misuse issues; one had also been diagnosed with PTSD. It was evident that a Complex Care Forum was not considered in order to determine how best to manage care and treatment moving forward. It was difficult to track how therapy, recovery and dual diagnosis referrals were made; it appears that in reality there were probably none.

4.115 The Review Team also considered how the clustering tool and care pathway model worked to facilitate Service users being placed on the correct pathway and having access to the most appropriate care and treatment. This is discussed in the report sections directly below.

Reflections from the Workshop

4.116 Workshop participants described a service with a limited access to resources outside of the main CMHT. This meant that referrals were often not made due to caseload pressures and the relative futility of seeking additional support.

4.117 Caseload pressures were also a key factor for the day-to-day running within CMHT services. This was described a factor for early discharge due to non-engagement for those Service Users with Personality Disorder.

Summary

4.118 In general access to 'mainstream' services tended to be good; however this appears to have been a 'one size fits all' approach. The Review Team understands that it could only make an assessment as seen through the lens of five cases. However these five cases all shared the same hallmarks – a preoccupation with medication and general monitoring, with very little ongoing practical support or recovery-focused inputs provided.

4.119 The five Service Users also had alcohol and/or substance misuse problems and a complex range of other needs. It was evident that the CMHT could not provide the degree of input required and that pressures on resources (perhaps also exacerbated by the current service model) meant that only specific inputs could be delivered.

4.120 The Review Team considered that the current lack of resourcing (combined with the service model) contributed to the cycle of discharge, relapse and re-referral. This way of working is to some extent counter productive and can foster dependence rather than reduce it.

Care Pathways and Evidence-Based Practice

Findings from the Desktop Review of the Clinical Records

4.121 Examination of the five Cases in the study identified the following:

1. Adherence to evidence-based practice was variable across the five cases. Where there were ‘straight-forward’ diagnoses of psychosis or Schizophrenia a relatively close match could be made with NICE guidance.

2. Service Users with Personality Disorders and/or dual diagnoses issues did not appear to receive the levels of service as set out in either local or national policy guidance. There was an apparent lack of synergy between services and there were also seeming gaps in service provision. Care pathways were often not in keeping with diagnoses and NICE recommendations. The services delivered all appeared to be based upon medication and community-based visits; there was a lack of therapy and recovery-based services.

4.122 Diagnostic ambiguity in two of the cases in this Review meant that it was sometimes difficult to understand the medication choices deployed; for example antipsychotic medication was routinely prescribed even though there was inter-team disagreement as to whether any psychosis was present or not. Therapy and recovery-based services were largely absent (apart from one patient where perhaps the least effective kind of therapy was provided on a ‘PD pathway’ when in fact he had Schizophrenia).

4.123 There appears to have been a ‘one size fits all’ provision for the five cases under review. If Service Users had any additional needs outside of medication and routine monitoring, these went largely unaddressed.

4.124 Of concern was the underlying culture that individuals with Personality Disorder could not be ‘helped’ outside of medication and monitoring processes; NICE guidance was not followed. The forensic service appears to have been the only access route for personality disordered Service Users to receive specialised care. This might be appropriate for individuals with a known forensic component to their history – but not sufficient for those without.

4.125 The use of the Care Clustering Tool was unclear due to the fact it did not appear to alter care pathway or service provision.

Reflections from the Trust at Interview

4.126 The Trust recognised that it does not work with 'care pathways' as such. Instead NICE guidance is met via Service Users being able to access relevant care and treatment inputs within the current CMHT model.

4.127 The Trust recognised that a sequence of mergers over the years has meant that there is a somewhat 'uneven' coverage of service provision across the Trust with different services within community teams sometimes having different names and functions. This means that the notion of 'universal access' across the Trust to a 'care pathway' might not hold up. The Trust has been actively working to address the issue of uniformity across its footprint.

4.128 The Trust is currently working on both care pathway development and service redesign. This is detailed below in part 5 of this report.

Summary

4.129 Seen through the lens of the five cases in this Review care pathway provision and evidence-based practice were partially met. Mergers, pre-existing service 'footprints', a lack of resource and caseload overload appears to have confused access for Service Users to the most clinically effective care and treatment for their needs.

4.130 Based upon the clinical records reviewed, and the feedback from the workshops participants, there also appears to be an underlying cultural issue where Service Users with PD are sometimes regarded as a 'resource problem'. This is something that the Trust should consider in depth and PD pathways should be expanded into mainstream mental health services and not left to the forensic speciality where resource is limited. It should also be taken into account; most Service Users with PD do not 'belong' with forensic services.

Care Clustering and Assessment

Findings from the Desktop Review of the Clinical Records

4.131 Examination of the five Cases in the study identified the following:

1. The Care Clustering Tool appears to be used as a 'stand alone' assessment as opposed to it being an aggregate of prior assessment

processes. The tool in itself is not designed to be a clinical assessment tool and should instead be used to assist caseload management and patient flow.

2. The use of the care clustering tool does not appear to have made any difference to the care pathway followed for the five Service Users in this review. No changes (e.g. care planning, change to service/team, or discharge) could be traced based on assessment practice. Periods of stability were not a seeming driver to access recovery-based services. Changes charted on the care clustering tool had little impact on the care pathway followed and the rating scales often ran counter to the narrative within the contact notes.

3. Ratings were not consistent and the forms sometimes appeared to have been completed by non-NHS staff. The Review Team remains uncertain as to how staff are trained in the use of the assessment tool. Transitions and discharges appear to have been managed without any reference to the care clustering process. It remains unclear exactly what function the care clustering tool has within the Trust.

Reflections from the Workshop

4.132 This was not discussed at the workshop.

Summary

4.133 It is of note that the Care Clustering tool is the one form that is completed with any degree of regularity. It appears to have been used as some kind of ‘shorthand’ risk assessment tool – which is not its purpose (NB: the completed Care Clustering Tools were sent to the Review Team as part of the Risk Management files archive).

4.134 Whatever the purpose of the Care Clustering tool (and whether it has been used incorrectly within the CMHTS or not) it is evident that Service Users were assigned to care pathways which either did not exist (e.g. the Trust did not actually have a Personality Disorder pathway but Service Users were assigned to one anyway) or had no bearing on the current working diagnosis/presentation. There appears to have been no recognition of the contradictions within the clinical records and Service Users were not reviewed accordingly.

4.135 This is an example of how Trust tools, policies and systems do not appear to reflect the service provision on the ground and are not linked one with the other.

Service User Involvement

Findings from the Desktop Review of the Clinical Records

4.136 Examination of the five Cases in the study identified the following:

1. Service User involvement and management varied across the five case studies. A diagnosis of Personality Disorder (whether as part of a differential diagnosis of part of a complex combination of other diagnoses) appears to have altered the perceptions of the treating teams as to how much service to provide and how to provide it. Two of the Service Users in the study had ‘Personality Disorder’ as part of their diagnostic profile – they were treated significantly differently from the other three Service Users. Disengagement and non-compliance with treatment was regarded as unacceptable and pressure (at times actual coercion) was used to enforce cooperation – discharge from service was also used with one of the Service Users.

   Levels of coercion and not being listened to with respect contributed to irretrievable breakdowns in the therapeutic relationship. There are a few examples of treating teams using unhelpful terms and phrases, and differences of opinion between the Service Users and their treating teams were often managed in a ‘high handed manner’.

   However it should also be noted that the three other Service Users in the study were involved, supported and treated with respect – despite disengagement and non-compliance issues.

2. Explanations regarding diagnoses and the resulting care and treatment (such as medication) does not appear to have been forthcoming. It is possible that this was done and not recorded – however there are several comments in the clinical records to show that Service Users were advised to ‘look things up online’ when they expressed either concern or curiosity.

3. Service Users were routinely invited to attend CPA meetings (with their carers if they so wished); this was good practice. CPA Reviews appear to have held discussions – but disagreements (which happened across all of the cases) were not always managed well; service was not as attentive or flexible as it should have been. Discharge was usually the answer, especially if the Service User was stable (even if of short-standing).

4. There were no advance statements found in the clinical records. Relapse and acute psychotic presentation were not discussed with Services Users when well and did not inform crisis and contingency planning.

4.137 The Review Team recognises that the clinical records evidence kind and compassionate care on the part of many individual practitioners. Some of the more problematic entries made are the result of practitioners not keeping themselves up-to-date in relation to the Services Users' current situation (e.g. in relation to confirmed rather than alleged sexual abuse). The problems in relation to Service User involvement and engagement appear to be 'cultural' and seemingly dictated by a combination of the service model and service pressures. These factors sometimes have a negative impact upon an inclusive, responsive and non-judgemental approach.

Reflections from the Workshop

4.138 The conversation focused on advanced statements – it was recognised that adherence to this was variable across the Trust but that it was a 'standard' approach for forensic services. Training had been provided to staff several years previously, but it was thought that many of these staff had probably since left the Trust.

4.139 Workshop participants reflected that the formal recording was *"another piece of documentation that's required… just another tick box exercise. That's how it feels to get completed and to be audited like, not meaningful. I think I this is a bigger issue, but the paperwork just needs to reduce drastically to improve patient care".*

4.140 Another key reflection was the use of the Mental Capacity Act (2005). There was a recognition that staff needed more training, supervision and guidance – even though mandated training was in place.

Summary

4.141 Workshop participants described an ethos of paying 'lip service' to some Service User issues. A valid point was made in relation to burdensome paperwork – but sometimes the time expended on relapse and crisis planning with Service Users (and their carers where relevant) pays dividends with them in becoming genuine partners in their own care and the maintenance of their recovery and wellness. A shortcut (while understandable in a service under significant time pressures) actually creates more work in the long-term and is also less efficient and effective.

4.142 Advanced statements should not be regarded as just 'another requirement' for an already stretched service to fulfil. Advanced statements are representative of true Service User engagement (particularly for those with severe and enduing mental illnesses who will remain with the Trust over a period of many years). A pre-existing advance statement for a person in crisis could possibly save days (or even weeks of time) as well as ensuring Service User dignity and involvement – of particular importance if their capacity is temporarily disrupted.

4.143 In general Service User involvement and support appears to work best with Service Users with a straightforward diagnosis of psychosis or paranoid schizophrenia. Even so, levels of choice are limited and the approach tends to be formulaic. In part this appears to be a cultural issue and in part it appears to be the result of services under significant caseload pressure.

Multi-Agency Public Protection Arrangements (MAPPA), Transition from Prison and Police/Probation Involvement

Findings from the Desktop Review of the Clinical Records

4.144 It should be noted that the events (in relation to MAPPA) examined by the Review Team took place over six/seven years ago. It is acknowledged that MAPPA and Offender Pathways might be managed differently now.

4.145 Examination of the five cases in the study identified the following:

1. The Trust has a MAPPA policy – however this is very long and difficult to comprehend; it is unlikely that practitioners have read this document and understand in full how MAPPA needs to work and how it actually works in practice.

2. Two of the Service Users in this study had been in prison both prior to, and during, their time with the Trust. Both had been in prison for prolonged periods of time for serious physical assault (e.g. a machete attack and other kinds of serious wounding) – they met the MAPPA level 2 criteria. Both were also on license with Probation Services. Both Service Users had offender services offered (e.g. Police Revolution Team and Probation); however these inputs did not appear to synchronise with the Trust's offender pathway policy expectations. Due to the concise nature of the clinical records it has been difficult to evidence Trust-based regular liaison with Probation Services. How mainstream services worked with MAPPA is entirely unknown as it not mentioned other than single references made 'in passing'.

3. It is a requirement of Trust policy guidance that individuals subject to MAPPA should be discussed at every CPA review; this was not achieved. It would appear that CMHTs were not involved in regular discussions and were not linked in with multi-agency considerations. One Service User appears to have also been open to forensic services (it is possible that this service maintained liaison with MAPPA) however there was no information sharing with the CMHT which was the main treating team.

4. Trust policy guidance requires care coordinators from community teams to attend MAPPA meetings; this was not achieved. It is of note that one of the Service Users in this study had three different care

coordinators assigned at the same time from three different agencies; this is possibly why no one from the CMHT attended as the ‘designated care coordinator’ was probably not from Trust-based services. This speaks of agencies working in parallel rather than in unison; the approach taken was clearly not person-centered. It is also evident that inputs from the different agencies were neither discussed nor shared in real time outside of the MAPPA process.

5. It is of note that the Review Team was not able to access clinical records from Forensic Services. This is a finding in its own right – it speaks of internal ‘silos’ present within the Trust’s own services. It is potentially to the detriment of Service Users and the maintenance of public safety.

6. A third Service User in this study was linked in to Youth Offending Services (YOT). Once again there was no evidence of joined up working. It is of note that after a relatively mild altercation between this young person and his sister – CMHT services considered referring him to MAPPA. This illustrates a lack of understanding of the MAPPA process and criteria. It is not known why issues were not kept within the YOT or why safeguarding processes were not considered.

7. There is no mention of Multi-Agency Risk Assessment Conferences (MARAC) for concerns about ongoing abuse and violence in a domestic context – this was warranted in at least two cases.

4.146 Seen through the lens of the five cases in this study the Review Team found that MAPPA, Youth Offending and liaison with Police and Probation Services were not managed in keeping with Trust policy guidance.

Reflections from the Interviews Held with the Corporate Team

4.147 During the corporate interview process MAPPA was discussed. Participants acknowledged that this was an area that required review and service improvement in tandem with multi-agency partners. Of note interviewees recognised that there were no existing processes within the Trust to monitor Service Users subject to MAPPA via any extant assurance or governance process. A suggestion was made that the Trust compiles a MAPPA register; this would enable the Trust to chart the progress of individual Service Users and would also facilitate resource allocation.

Summary

4.148 The issues identified with MAPPA reflect those already identified in relation to multi-agency working. It is evident that Trust policy guidance does not map directly onto the reality of service provision.

4.149 Of concern was the general lack of day-to-day professional curiosity. Service Users who are subject to MAPPA, YOT, or on license with

Probation Services represent a relatively small but high risk sub-set of the caseload. It would be reasonable to expect risk assessment and diagnostic formulation would take this into account. Whilst understanding the pressure care coordinators are under this sub-set of Service Users will require heightened levels of liaison between services and agencies; these Service Users are priorities in relation to risk and public safety. It is a basic tenet of psychiatry that ‘past behaviour predicts current behaviour’. In two of the cases in the study there were recorded histories of actual, serious violence and assault; in a third case there was evidence of serious and escalating behaviours.

4.150 Of significance is that the Service Users mentioned above had a myriad of service/agency involvement; one Service User had up to 13 services and agencies providing inputs. There appears to have been no synchronisation. Opportunities for information sharing and risk management were missed; MAPPA, YOT and other multi-agency processes were seemingly not followed.

4.151 Future improvements are not for the Trust alone. In order to achieve the synergy required systems and process will need review across all of the relevant agencies.

Part Five

Conclusions, Lessons for Learning, Focus for Future Service Development

Conclusions

Conclusions Regarding Internal Investigation Processes

Internal Investigation Process

5.1 The Review Team understands that the five case studies examined in this review provide a snapshot of a process which was under development at the time. The majority of the cases were investigated, not only during a period of transition, but also during the early disruption caused by the COVID pandemic.

5.2 At interview Senior Trust Officers explained that there had been a backlog of Serious Incident Investigations and pressures on staff; an external consultancy had come into the Trust to advise and to help re-structure the process to ensure both effectiveness and efficiency. The Review Team was also told about the additional support that was now being provided for Lead Investigators, together with a move towards a more open learning culture.

5.3 Clearly this is a work in progress; however the Review Team has seen evidence that the quality of internal investigation processes and reports is improving and becoming embedded. The Review Team can attest to the openness and transparency of the Trust's culture. Workshop participants, and the Senior Trust Officers who were interviewed by the Review Team, all demonstrated an open culture, focused on learning and service improvement. This is to the credit of the Trust.

5.4 Moving forward the Trust would benefit from a more structured approach to include:

- a standardised process to provide clear instruction and support to clinical staff;
- a standard report template;
- the inclusive development of terms of reference;
- protected time for lead investigators and investigation team colleagues;
- the consistent use of an evidence-based approach when identifying findings and conclusions;
- the inclusive development of recommendations;
- an inclusive method to share learning;
- the development of an investigation archive (essential for internal audit and assurance, Inquests and independent investigations);
- a more transparent endorsement and sign-off process.

5.5 The advantage of such an approach would ensure standardisation across the Trust, some key expectations against which to audit and provide assurance, and a clear level of expectation for lead investigators.

5.6 Of note: the new National NHS Patient Safety Incident Response Framework is about to be launched; this provides an opportunity for re-alignment and a review of how well recent improvements have been embedded.

Duty of Candour: Service User, Carer and Victim Involvement and Support

5.7 A key area that still requires embedding is the involvement and support of Service Users, their carers, families and victims (especially if not previous known to the Service User). The Trust needs to reconsider aspects of its Incident Policy and it should provide more robust guidance in relation to Duty of Candour responsibilities. From an examination of the five cases in this Review it is apparent that Duty of Candour responsibilities need to be clarified. The Trust should ensure that its practice is in alignment with national best practice expectation, policy needs to be more explicit, and lead investigators need more instruction and support.

5.8 The Internal Investigation reports mentioned ‘support’ being given to Service Users and carers; the nature of this support was not described. Support should not consist of ‘a meeting’ or a sequence of ‘follow-up calls’. The Trust should consider how best to offer counselling and trauma support to Service Users, carers, families and victims alike. It should never be underestimated how deeply traumatic a homicide or a non-fatal stabbing can be to carers, families and victims – the 2005 updated Department of Health guidance laid a clear responsibility upon provider Trusts to source suitable support – regardless of how long-term and complex that turned out to be.

5.9 Support to the Service Users who perpetrate homicides and/or non-fatal assaults often need skilled, consistent support and therapy intervention. Provider Trusts sometimes assume that being an inpatient (or still being on a mental health caseload), somehow confers the necessary degree of inputs required – it does not. The fragility of a Service User with pre-existing mental health problems should not be underestimated; their needs require careful and ongoing consideration with specialist contributions.

Summary

5.10 It is apparent that the Trust has undertaken a wholescale review of its internal investigation process; this process still requires embedding and monitoring, particularly following the review of governance arrangements across the Trust in April 2021, moving to a Locality Network model. Two years into the new process it is probably time for an audit and review to establish whether it is delivering against pre-set expectations and policy. Re-adjustment, standardisation of approach and ongoing quality review will be required moving forward; especially in the light of NHS England and NHS Improvement policy change in the form of the new Patient Safety Framework.

Conclusions from the Thematic Pathway Review

Primary Reflection

5.11 The Review Team has one particular conclusion to make which helps put the following narrative into context. Basically, it is evident that there was a great deal of activity across all five cases over a number of years. It was also evident that practitioners and treating teams worked very hard to deliver care and treatment. However a significant amount of the activity was not meaningful; not meaningful in that it was not based on robust diagnostic process and good general assessment practice. This meant that ‘best fit’ care and treatment was not always provided and was not always able to maintain wellness and recovery. This was compounded (and to a large extent caused) by service structures (e.g. electronic recording systems and service models) that were not as effective as they needed to be. The Review Team was told at the workshop that staff were experiencing exhaustion and burnout; it was also told that this served to perpetuate a culture of ‘short cuts’ which in turn contributed to the worsening of Service User presentations and increased pressures on the caseload. In order for service to change for the better underlying systemic issues need to be both understood and improved. It is acknowledged at the time of the workshops, COVID-19 impact was being felt due to staff sickness increases and also an increase in demand being seen across a number of mental health services.

5.12 The question posed by the Terms of Reference for this review was: *“If a service user accessed services today with a similar history/problem – what would be different”?*

5.13 Despite the incidents linked to the five cases under review occurring between two and three years ago (and despite significant service developments occurring within the Trust since this time) it is evident that the accounts given to the Review Team by Trust staff (in November 2021) describe a current service with some of the same underlying systemic challenges and therefore the same challenges to the maintenance of patient and public safety. On the balance of probability the Review Team concludes that current Services Users will still face the same deficits in services that the five Service Users in this study experienced. However there is an acknowledgment of the transformation and improvement work undertaken by the Trust to date and also planned for the future.

General Reflections

5.14 The Review Team findings and those of the two thematic reviews conducted by the Trust in 2020 where largely in accord. The Trust had already established where consistent service delivery issues existed. The Thematic Pathway Review process has been able to build on this work to ensure a more targeted and systems focused approach can be taken.

5.15 The findings from the desktop review of the five cases in the study were validated by the workshop participants.The workshop participants were also able to provide additional insights as to *why* key omissions in service consistently occurred and *what* was being done to improve things.

5.16 The high-level interviews with Trust senior officers also added more insights as to where service improvements needed to be focused moving forward.

5.17 A key outcome of the Review is the understanding that a 'matrix of interconnectivity' exists between the identified themes. In order to maximise learning and service improvement opportunities it will be necessary to work on the underlying systemic issues in order to address the 'perennial issues' (such as risk assessments, care planning, disengagement from service etc.) which are usually identified during any mental health investigation process.

5.18 Current NHS investigation practice is effective at identifying *what* goes wrong. It is of note, that since the original mental health homicide investigation guidance was published in 1994 (HSG (94) 27), investigation findings have all been similar the length and breadth of the country. The National Confidential Inquiry into Suicide and Homicide has commented on the 'never-changing' findings, conclusions and recommendations yielded from sustained investigation activity; the problem is that investigation process alone has not been able to bring about the levels of patient safety improvements that had been hoped for.

5.19 Collegiate working between the Review Team and the Trust provided the opportunity for a deeper more systemic understanding of the issues that needed to be explored. It is evident that the usual practice of addressing the myriad 'perennial' issues identified as a result of NHS investigations serves to provide a temporary 'fix' that is not sustainable; the additional caution against this approach is the false assurance that it provides. Activity (whether it is in the form of investigation process, audit or thematic review) needs to be meaningful; a pause for deeper reflection (such as a thematic pathway review) is merited on a regular basis. The time taken to conduct a review of this kind is likely to be time well invested.

Notable Practice

5.20 The Review Team found several areas of good practice: dedicated care coordinators who worked hard with Service Users; examples of robust policy documentation (such as the managing disengagement policy); and a good standard of inpatient multidisciplinary assessment processes.

5.21 Notable practice (in that it was over and beyond what could reasonably be expected of an NHS provider service) was identified in one area; that of organisational learning culture.

5.22 The Review Team found the Trust to be open to learning and reflection. Trust participants were enthusiastic, focused and supportive of the Review process. All contributions were made in an honest and open manner with the emphasis on patient safety and service improvement. The Review Team found this to be impressive.

Lessons for Learning and Focus for Future Service Development

Systemic Prioritisation

5.23 The Findings from the Review have been placed under five main headings. The report details a complex interweaving of issues and themes which has identified a multitude of areas that require action. However the Review Team is of the view that whilst these areas will all require attention, the Trust needs to focus in the main on the five headings below in order to bring about change on a deeper systemic level.

5.24 An example of how identifying key systemic headings will work can be illustrated by the following example. Caseload overload appears to have become a key factor in routine ‘short cuts’ being taken. Workshop participants recognised this to be ‘de-skilling’ and that this is slowly leading to a culture change where policy adherence is no longer considered necessary or ‘doable’. This means risk assessments are not completed and care plans are ‘cut and paste’. The traditional approach would be for an NHS investigation to require (for example) an audit of risk assessment process, or remedial action to be taken with identified staff, or for staff to be ‘reminded’ to adhere to policy; none of which is usually effective. Workshop participants identified caseload overload and Service User complexity to be exacerbated by the current CMHT service model, the lack of connectivity between record keeping systems and Trust policy and procedure, and poor accessibility to specialist services for referral. Therefore it is evident that focusing on the ‘symptom’ (e.g. a lack of risk assessments) is not going to affect the underlying cause (e.g. a need to streamline service and system via service model re-configuration).

Lessons for Learning and Selected Areas for Future Focus

5.25 It should be acknowledged that the five headings below have a high degree of interconnectivity and overlap.

Multi-Agency Working

5.26 Multi-agency working requires a review to ensure integrated policies and protocols are agreed. There is a need for all agencies and services to work in a more Service User-centered manner. This should prevent duplication of effort and should also prevent omissions from occurring (particularly in relation to safeguarding and protection of the public). This should lead to a more efficient and effective use of resource.

5.27 A key factor identified by the Review Team was that Service Users had to work very hard to remain engaged with a myriad of agencies/services that were not working in partnership. Intense levels of activity were noted – but this level of activity did not appear to make a positive impact upon the Service User and their carers.

5.28 It is evident that child safeguarding and MAPPA processes are not working in accord with national policy expectation. For example, despite the recommendations set over 20 years ago by the Laming Inquiry there appears to be no access to a centrally-held child safeguarding recording system. It is essential that connectivity is developed and maintained.

5.29 It should be acknowledged that when Trusts merge and expand their boundaries, or when Local Authorities change their working practice, the entire health and social care economy is affected. It does not take long for what once might have been an integrated system to become fragmented. This requires ongoing networking, relationship building, planning and general vigilance.

Service Model Re-Configuration

5.30 Service model reconfiguration is currently ongoing at the Trust. National changes to service provision, combined with Trust mergers and remodelling, require periods of review and staff consultation. Workshop participants were able to articulate how the current service model slows down patient flows, duplicates effort, and creates inherent ‘pockets of risk’. The current model was seen as ineffective and as creating additional workforce pressures.

5.31 Many of the barriers to effective working appeared to be inter-Trust issues – several of which appear to be the legacy of recent expansion and service acquisitions. Workshop participants said they did not really ‘know’ or ‘understand’ how some aspects of their own organisation worked - this led to a somewhat ‘heads down’ attitude where individuals focused on the work ‘in front’ of them. Staff were described as being *“tired and burnt out”.* Non-adherence to Trust policy guidance, fragmented multi-disciplinary team working, and poor clinical record keeping were all regarded as a direct result of underlying systemic and service model pressures.

5.32 COVID has presented additional challenges on top of those already present; however workshop participants did not choose to dwell on this citing more fundamental areas that required review and change. Moving forward it is evident that Trust staff have strongly-held views and high levels of insight as to how service improvements should be implemented; the Trust is currently engaging its staff in the modernisation process; this is good practice.

Clinical Record Keeping and Professional Communication

5.33 When there are challenges with multi-agency working (combined with fragmented service models), clinical record keeping and professional communication have to work harder to ensure seamless provision and continuity of care for Service Users.

5.34 The Trust currently has a suite of electronic record keeping systems that do not appear to foster safe, collegiate and effective working. Combined with caseload overload, and difficulties with accessing and working with inter-Trust and multiagency services, this creates another layer of challenge and frustration.

5.35 Policies (such as those for safeguarding, CPA and risk management) are not integrated one with the other – neither is the accompanying paperwork and assessment documentation. Not only is there significant duplication of the information recorded (due to a lack of integration) there are also significant omissions. The current documents are myriad, time consuming to complete, and the underpinning information held on RiO difficult to access. When individuals try to conduct assessments they often run out of time due to the myriad forms and they also cannot be certain that they have been able to access the correct and most up-to-date information from the multitude of systems available (most of which they do not have access to).

5.36 Of significance is the resulting insidious change to the ‘culture on the ground’. Short-cuts are common place (such as cut and pasting of often out-of-date information) and an overly concise record is developed. The Review Team was told practitioners understood well how to confound a quantitative audit and that this was reflected in day-to-day practice.

5.37 Complex and fragmented services, combined with a model that requires Service Users to be ‘moved through the system’ on a regular basis, reduces continuity of care. Workshop Participants identified that Service Users sometimes remained with services for a few weeks only before being transferred to a different community team – this would also lead to a change in consultant psychiatrist. This increased the workload and also increased the likelihood for poor levels of handover; this provides an example of how challenges related to the service model also impact upon the challenges intrinsic to record keeping and professional communication.

Development of Clinical Care Pathways

5.38 The Trust is currently in the process of developing clinical care pathways. In conjunction with the re-configuration of the service model it will be possible to provide a more focused framework for clinicians and Service Users alike.

5.39 Robust diagnostic process, access to both mainstream and specialist services, and the development of operational policies should all become embedded into a streamlined pathway. This will focus workforce activity and should also provide a widening of care and treatment options within the existing resource available.

5.40 The distinct advantage of developing a care pathway model is that monitoring and assurance can be undertaken in an evidence-based and systematic manner. It is a key lesson for learning that complex service provision requires a high degree of planning and a structured, evidence-based framework for delivery is also required. Care pathways also provide the opportunity to align Trust services, policies and guidelines – large service providers often develop ‘organically’ over a period of years – especially when mergers and acquisitions have occurred – it is good practice to review after a period of change.

Strengthening Trust Audit and Assurance Systems

5.41 It is apparent that Trust audit systems are not sensitive enough to detect the extent to which Trust personal are non-compliant with policy and procedure. It is also apparent that policy guidance and documentation templates do not always align and that gaps and omissions caused by this are rendered ‘invisible’ to audit (e.g. child safeguarding).

5.42 The Review Team found the suggestion of an ‘on the ground’ culture of staff non-compliance with policy guidance; this was driven by caseload overload and frustrations with complex and ineffective systems.

5.43 It is a fact that we find audit ‘answers’ to audit ‘questions’ – audit will only provide feedback to what is specifically asked of it. The Trust needs to consider what it is auditing, how standards are going to be assessed and monitored, and how to introduce a qualitative system to sit alongside its current quantitative processes.

Part Six

Current Service Developments within the Trust and Recommendations for the Future

Current Service Developments and Improvements

6.1 The Trust has embarked upon a significant journey of improvement since 2019, following receipt of a Care Quality Commission (CQC) inspection and a system-wide review of Mental Health. This is being taken forward by a newly appointed senior leadership team, including new Board members and a new Network Leadership model; this to ensure enhanced clinical and operational leadership across the Trust. Significant transformation and improvement programmes have been progressed, despite the challenges faced with COVID 19, and the Trust continues to work with commissioners to invest across services and pathways of care, utilising the Mental Health Investment Standard (MHIS), which is a national priority to address recognized historic under funding of Mental Health Service provision. The Trust welcomes this work to enhance and further support its improvement journey.

Multi-Agency Working

6.2 Multi-agency working has and remains a key focus for the Trust in the delivery of safe and quality patient care. The Trust has built strong relationships with providers who input into the care of patients under Trust services. This includes regular engagement with CQC and commissioning teams, co-working with Probation services, co-investigations with local health care partners, and further developments in areas of safeguarding, policy, and shared access to patient reporting systems.

6.3 There are multi-agency forums that the Trust attends and relationships have been strengthened, supported by increased cross organisational working during COVID 19. For example, a Listening into Action programme and workshop has been held relating to Dual Diagnosis with an online resource portal and Dual Diagnosis Champions created internally, with more clarity regarding referral pathways.

6.4 The Trust works in partnership across the system with partners as part of the Suicide Prevention Oversight Board. There are also similar arrangements for Homicides that have been developed, ensuring that there are multi-agency strategies in place to prevent harm to service users and the public.

Safeguarding

6.5 To ensure the integration of safeguarding across Trust and Agency services, the leads for MAPPA and safeguarding have been working closely together to strengthen joint working, information sharing where required, and recording of information on RiO.

6.6 The Trust's MAPPA Policy has been aligned to the national MAPPA policy and has been enhanced by a MAPPA leaflet available to all staff and Service Users. The Trust has also developed a MAPPA staff guidance document, which simplifies the process into a flow chart and list of forms to be completed within the process.

6.7 Amendments were introduced to RiO in March 2022 to support Trust practitioners in recording the application of Routine Safeguarding enquiry. This included the integration of assessments relating to the safeguarding of children. To support practitioners to understand which documentation is required to report and asses the safeguarding of adults and children, this is covered within annual mandatory safeguarding training. Advice can also be sought from the safeguarding team, and referenced in Trust policy.

6.8 The safeguarding champion's model has been implemented Trust-wide and is delivered in line with Trust policies and procedures, training and the Local Safeguarding Adult Board (LSAB) and the Children's Safeguarding Assurance Partnership (CSAP) guidance. The integration of the safeguarding champion's model across the Trust offers a robust support process within each service area in conjunction with the support offered through Trust Safeguarding Advice and Consultation.

Service Model Reconfiguration and Transformation

6.9 The Trust launched a new operating model on 1 April 2021, based on five networks supported by new clinical and managerial leadership.

6.10 This leadership model offers additional support and leadership at a network level, with the senior leadership teams being closer to the teams delivering services, to enhance the way the Trust operates moving forward. It also aligns Trust services and leadership to local neighbourhoods, ensuring that the local health population needs are met and that transformation plans meet the changing needs of patients, service users and their carers.

6.11 The Trust is currently delivering an expansive programme of system-wide, organisational and service transformation, which will significantly improve the quality of not just the services the Trust provides, but will also improve health services across the whole of the Trust's provision.

6.12 To ensure the maintenance of such good patient care during the COVID 19 pandemic, the Trust has increasingly been working collaboratively with other provider trusts, and across the wider health and care system. There is now a great opportunity to build on this collaboration to further improve health and care. To this end, the five provider NHS Trusts have come together as a Provider Collaborative to agree joint priorities as how best to deliver them for the benefit of people across the area, together aiming to drive up quality by sharing and standardising best practice to reduce unwarranted variation and duplication.

6.13 The Trust is the Lead Provider for specialist mental health services, working as part of Lead Provider Collaboratives (LPC) across the area; Children and Young People Tier 4 Mental Illness, Eating Disorder and Learning Disabilities Services, and Adult Low Medium Secure Specialist Services.

6.14 The Children and Young People service successfully transferred from NHSE/I with delegated commissioning responsibility passed to the Trust on 1 October 2021 and adult secure services on 1 November 2021. The focus of the Children and Young People LPC, is to establish effective partnerships to deliver quality care across CAMHS care pathways, offering greater support within the community to reduce reliance on inpatient services and specialist placements, keeping young people closer to home and in the most appropriate care setting for their needs.

6.15 The Adult Secure programme, aims to establish a clinical pathway that will reduce overall reliance on inpatient care by developing community support services to enable admission avoidance, facilitate discharge and reduce length of stay.

6.16 Improved pathways of care, where different services work more closely together, will be developed alongside improved community infrastructures through partnership, including the voluntary sectors and non-NHS services.

6.17 As part of the NHS Long Term Plan and learning from patients, carers, staff and stakeholders and experiences through COVID 19, the Trust also has ambitious plans to transform community mental health services for adults and older adults across the area, through enhanced community-based support for people living with moderate to severe mental illness and complex needs. The new model will focus on supporting people living in their communities with long term severe mental illness, bringing together primary and secondary care with social care, other local authority services, third sector and local communities.

6.18 In 2020/21 the Trust received additional investment into Community Learning Disability Services and into Community Autism Services and is working with commissioners to ensure service models meet the needs of the local population.

6.19 In the past year (during the COVID-19 pandemic) the Trust launched a variety of different innovations and initiatives to respond effectively to increasing high demand for services. These include working with system partners to implement new Mental Health Urgent Access Centres (MHUACs). Established as a safe and calm assessment space for those who are experiencing urgent mental health needs, the MHUACs focus on therapeutic needs, meaning those in distress can be more effectively supported – lowering the need for admission in some instances.

6.20 The Trust also launched a Crisis Line telephone support service, which operates 24 hours a day, seven days a week, with trained medical professionals on hand to provide immediate assistance to those who need it. This crisis line enables callers to receive a mental health assessment and referral on to appropriate services.

6.21 The Trust is also working on plans for its ‘Initial Response Service’ to be Trust wide; this is a new single point of access for all those experiencing mental health issues or crisis, which will work in a similar way to NHS 111. This will streamline and simplify mental health access for people across the area. In addition Street Triage Services has been expanded aligned with IRS implementation; a collaborative partnership between the Trust, the local Ambulance NHS Trust and local Constabulary to help people experiencing a mental health crisis.

6.22 The CMHT national Transformation Programme is being implemented across the Trust. This is part of a national transformation programme, of which the Trust is an early adopter, to help develop PLACE based community mental health service models, modernising the CPA approach, working with partners, to offer whole person, whole population interventions and health approaches.

Clinical Record Keeping and Professional Communication

6.23 In late 2020, the Trust introduced RiO, the new patient record system, which replaced ECR. The change in systems has allowed for the alignment of RiO records with the Lancashire Patient Record Exchange Service (LPRES), so all primary and secondary care clinicians across Lancashire and South Cumbria can access patient records on their clinical systems. The development of the RiO system is ongoing, and currently the Trust is at a stage of development with service users and clinicians to determine which other suitable documents/information should be shared from RiO to LPRES.

6.24 Following the introduction of RiO (electronic patient care records) assessment templates for safeguarding were integrated into the system. Further amendments were introduced in March 2022 to support Trust practitioners to record routine enquiry within case records. Included in these system amendments were access to care plans, crisis contingency plans, discharge letters to GPs, and daily summaries of care. The optimisation work continues across the Trust, being led by Clinical Information Officers, roles which the Trust has invested in at Trust level and Network level.

6.25 The Trust’s new Digital Strategy developed in 2021/22 will accelerate the Trust towards new and innovative ways of working that improve patient outcomes and the care experience, as well as efficiency for staff. The Trust has recently become the first mental health Trust to achieve accreditation as a Digital Leader for completing all the requirements of the Global Digital Exemplar (GDE) programme. Following the delivery of 19 projects over a three and a half year GDE Fast Follower programme, the Trust has been awarded HIMSS Level 5 status, which is an international standard for digital adoption.

6.26 The Trust's current Health & Social Needs Assessment is under review within its continuous improvement program and will become the new Patient Core Needs Assessment, which will be electronically available to all practitioners involved in a service user's care. The Trust plans to ensure from this QI programme that all Service Users have a good quality, current version of the Trust's identified core needs assessment in their electronic care record, which will be readily accessible and actively used by clinicians to inform & manage clinical risks and day to day care. In the interim the Health & Social Needs Assessment remains in place and there is continuous work to ensure this assessment fully retains the key historic and current service user information that informs care.

Person-Centered Approach

6.27 The Trust has invested significantly into its Person-Centred Framework, which is a key part of its Service User and Carer Involvement Strategy. Significant work underway as part of this is:

- establishment of a Trust and five Network Service User and Care Forums across the Trust footprint, to ensure meaningful co-production is in place; Chair of Service User & Carer Council attend the Board of Directors;
- accelerated roll out of Triangle of Care, to ensure there is education, awareness amongst staff regarding the important role that carers plan;
- drop the jargon campaign across the Trust, so that language being used can engage service users and carers, as part of their plan of care;
- Investment in Dialogue Plus across the Trust, as a tool to ensure routine service user-clinician meetings are therapeutically effective, with goal based outcomes being agreed and monitored- this has been piloted on the Trust's Rehabilitation Ward and is being adopted Trust-wide;
- care co-ordination policy being reviewed with production from service users, carers and staff, to support Community Mental Health Transformation programme.

Development of Clinical Care Pathways

6.28 The Trust is currently in the process of a full review of its clinical care pathways aligned to transformation. As part of a newly developed Clinical Services Strategy, there are a number of transformation programmes underway to transform pathways in adult and older adult mental health, including the urgent care pathway, rehabilitation and community services via the following transformation programmes: Urgent Care Programme, Rehab Programme, Community Mental Health Transformation Programme and the IRS Programme. There has also been a review of the Personality

Disorder Pathway within the Trust, with support from Cumbria, Northumberland, Tyne and Wear (CNTW) Foundation Trust, who the Trust has been working with via a strategic partnership agreement.

6.29 In order to take forward these pathway reviews, the Trust has developed a Clinical Senate and a number of Trust-wide Best Practice groups to ensure that evidence based pathways are in place and developed for Trust clinical services, this also includes various Trust partners in the delivery of these pathways.

Trust Governance and Assurance System – Including Audit

6.30 In the 2019 CQC inspection report, the Trust's governance, risk management and learning processes were criticised with regulatory breaches being incurred for governance across core services inspected and the Trust. Since 2019, a robust improvement plan has been put in place for governance and risk management.

6.31 The Trust's incident, complaints and Duty of Candour processes have been completely reviewed, with standardised policies, processes, report templates and investigations training being put in place. A weekly Executive led Safety Summit is now in place, with Network Safety Incident Review Panels (SIRPs) which also meet weekly. Here learning from incidents are discussed and Serious Incident investigations are quality assurance checked, so there is a multi-disciplinary review of each case and actions are overseen and monitored. There are central safety specialists, who have specialist training in investigations and human factors, who support investigation leads within the Trust. External investigators are also sought for high profile/high risk investigations, such as homicides. The Trust has been working towards implementing the new National Patient Safety Strategy and as part of this, has implemented a Just Culture Charter, enhanced safety and improvement training and strengthened its round-table learning approach.

6.32 A full review of the Trust's policy and procedural framework has been undertaken to ensure that it is robust and fit for purpose, including having training in place for policy authors and staff to help implement policy standards, having clear policies that are outline contemporary practice and monitoring policies and standards aligned to accreditation and auditing of practice e.g. the engagement policy and procedures.

6.33 The Trust's clinical audit program is aligned to local and national priorities with the overall aim of improving patient outcomes and reflecting regulatory and commissioning requirements. The Trust clinical audit programme reports to the Patient Safety & Effectiveness Sub Committee for awareness of the topics and progress of clinical audits registered through the Clinical Audit portal. Regular summary clinical audit reports, together with recommendations, are communicated to all relevant areas of the organisation and Trust committees, in addition to the newly formed Best Practice Groups.

14 Recommendations

Background

6.1 It should be understood that the Trust has been on a significant journey of service improvement since 2019; the beginning of this journey is charted in the Care Quality Commission inspection report of September 2019. In May 2019 the Trust was categorised as being offered ‘targeted support’ by the NHS Improvement Single Oversight Framework. Following this a mental health quality committee was set up with membership from (the then) NHS England, (the then) NHS Improvement, stakeholders, commissioners and regulators to develop a whole-system strategy for mental health across the integrated care system. A significant amount of focus was placed on multi-agency working and how to improve it. It was recognised at this time that key actions were not the sole responsibility of the Trust and that ownership by multi-agency partners and NHS commissioners alike was required to redesign the care pathway across the mental health services footprint.

6.2 Since this time the Trust has launched its five-year improvement strategy (April 2021 – 2026) which encompasses care pathway redesign and service remodeling. The Trust is modernising and implementing a wholescale service transformation agenda which encompasses in full the systemic issues found to be in need of improvement by this Independent Investigation. Running alongside this are the two thematic reviews that the Trust conducted in 2020 (please see paragraph 1.14) and the subsequent recommendations that were set.

6.3 The Review Team is aware that its work reviewed services as they were prior to 2020; the documentary findings (based on the clinical records) therefore relate to the service provision of over four years ago. The workshop held with Trust participants took place in November 2021 and represented a ‘snapshot’ of how service was at that time as the Trust began its transformation processes. It should be recognised that service improvements are moving forward and the Trust has provided an update of progress to-date (provided in the report section directly above) and the recommendations set out below are intended to support the ongoing service development and performance management processes that are already in train.

6.4 The Review Team has not been privy to all of the outstanding issues or the levels of performance monitoring that have taken place to-date in relation to governance and improvements. This is because we were not able to work with the Trust and the commissioners in a ‘roundtable discussion’ – neither was it possible to develop recommendations with any active participation from them. The recommendations below are ‘high level’ and systems based; they fall into two distinct categories: the first requiring a degree of oversight (and possible further development) from the integrated care system, and the second requiring practical, operational service change within the Trust, requiring a less intensive level of oversight and support from external bodies.

Ethos of Recommendation Setting

6.5 The NHS England *Patient Safety Incident Response Framework* (2022) advocates the embedding of the *"patient incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management".* As such when a known body of work is ongoing (that is already addressing identified areas from incident investigation) then it is advocated that any further response is coordinated and synthesized with what is already known and incorporated into patient safety management processes. This guidance reflects the approach taken by the Independent Investigation Team in the setting of recommendations.

6.6 An investigation of this kind is asked to identify areas that require improvement; therefore the subsequent recommendations and action plans should be designed to achieve these improvements. Recommendations and action plans should consider:

- what is required;
- what needs to be achieved;
- which particular risk/s are being mitigated against
- who needs to take responsibility for implementation.

6.7 Recommendation setting is the first part of the process that develops an implementable action plan. The action plan will be developed with Trust by key commissioning stakeholders following the publication of this report. The action plan will specify:

- milestones, aims and objectives;
- performance targets and indicators;
- methods of audit and evidence collection, progress review and assurance;
- costings and resource implications;
- indications of where multi-agency inputs are required;
- timeframes and completion dates;
- methods of accountability and oversight.

6.8 With this in mind the Review Team has reviewed the progress made by the Trust in relation to the findings and conclusions of this Thematic Pathway Review. The recommendations have been set with the intention of supporting the work that the Trust has already embarked upon and to also ensure that future strategic planning incorporates inputs from commissioners particularly where multi-agency partners also need to make significant contributions to planning, process and service provision.

Category One: High-Level Recommendations Requiring External Oversight and Further Development with Stakeholders and Commissioners

Recommendation 1: Clinical Care Pathways

6.9 **Areas Identified for Improvement:** The Thematic Pathway Review Team found myriad areas requiring improvement related to clinical care pathways; these were applicable to Personality Disorder, Psychoses, Paranoid Schizophrenia and Substance Misuse. The identified issues included those at the beginning of Service User pathways (diagnosis, allocation to the 'best fit team', care and treatment) right through to those in the middle and at the end of care pathways (crisis management, recovery-based interventions, and discharge planning). The National Institute for Health and Care Excellence (NICE) provides detailed guidance for the delivery of clinical care pathways for all major mental health conditions in England; in the case of the service users in this review these guidelines were not adhered to in a consistent manner.

6.10 **Progress Made:** The Trust is developing clinical care pathways in conjunction with its service transformation. The Trust has developed a Clinical Senate and Trust-wide Best Practice Groups to both oversee and implement the work. At the time of writing this report the work to implement new clinical care pathways was in the process of being embedded.

6.11 **Action Required:** Action is required to ensure evidence-based practice is delivered by the Trust, this to minimise the risks associated with less optimal care and treatment being delivered associated with poorer clinical outcomes. The Clinical Senate and Trust-based Practice Groups should:

1. **Undertake a mapping review of the findings and conclusions of this report against the Trust's newly embedded care pathways. This to ensure the care pathways cross-match with the areas identified for improvement as a result of this Investigation.**

2. **Undertake a selection of case study reviews against the standards proforma used for this investigation process. This will provide an early indication to evaluate the effectiveness of the new care pathways when mapped against the provision of basic building blocks of care' issues.**

Recommendation 2: Service Model Reconfiguration and Transformation

6.12 **Area Identified for Improvement:** Two areas for improvement were identified. First: the Service Users whose care and treatment was examined in this Review experienced difficulties accessing the range of services that they needed when they needed them (e.g. forensic assessment, substance misuse services, assertive outreach and rapid access to the 'best fit' community-based team). Second: Trust workshop participants recognised that the past configuration of community mental health teams slowed down referrals and made a negative impact on continuity of care.

6.13 **Progress Made:** The Trust launched its new operating model in April 2021. The new model seeks to reconfigure community-based services and improve access; this is in keeping with the NHS England National Transformation Programme.[2] This national programme also requires modernising the Care Programme Approach (for which the Trust is an early adopter) and working with both NHS and multi-agency partners to support people with mental health problems. It is evident that the Trust is working collaboratively with external partners and stakeholders to redesign and modernise its services, this to ensure improved access and patient-centred working to offer whole person, whole population interventions and health approaches.

6.14 **Action Required:** The transformation process comprises a five-year strategic plan. At the time of writing this report the Trust and its partners had been working on service change for 18 months. Action is required to focus on the progress made to-date in order to minimise the risk of a reoccurrence of the access issues identified by this Review. The Trust, its commissioners, partners and stakeholders should:

1. **Review the strategic plan to ensure that all of the identified areas for improvement identified in this report have been addressed and have been incorporated. Particular focus should be placed on access to community forensic services, substance misuse services, crisis intervention and recovery-based services.**

2. **Review progress in relation to implementation as set against the findings and conclusions of this report. A mapping exercise should be conducted to ensure there are no omissions in the strategic plan.**

3. **Review the costs (and other implications) of any additional service additions and changes that might be required.**

Recommendation 3: Multi-Agency Working

6.15 **Areas Identified for Improvement:** Over the past five years the Trust, the Care Quality Commission, NHSE/I and this Thematic Pathway Review have identified key areas requiring improvement in relation to multi-agency working. Information sharing, partnership working (systems and culture), and a lack of policy alignment have been, and remain, priorities. This Review found that the service users examined were not always placed in the centre of the service provision offered; instead they had to work very hard to engage with multiple services and personnel who were not working

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

in partnership. This was, at times, to the detriment of their care and treatment.

6.16 **Progress Made:** Over the past four years (following the CQC 2019 inspection) there has been regular engagement with the CQC, commissioning teams, Probation Services and local health care partners. This has led to developments in areas of safeguarding, policy, and shared access to patient reporting systems. There are multi-agency forums that the Trust attends and relationships have been strengthened.

6.17 **Action Required:** During the Review process it was evident that multi-agency collaboration was improving and that there was a strong willingness for partnership working. What was not so evident was how the inputs of the past four years could be evidenced in a practical manner when it came to examining an actual Service User pathway (such as those for the Service Users in this study). Strategic thinking needs to be implemented 'on the ground' and in a practical manner to minimise the risk of service users receiving fragmented service provision. The Trust, its commissioners and multi-agency partners should consider:

1. **Realigning all relevant policies and protocols to include: information sharing, safeguarding, MAPPA and collaborative working. Short information leaflets short be made available to facilitate usage.**

2. **Realigning incident investigation and lessons for learning work in order to promote a whole-systems learning and improvement approach.**

3. **Evaluating the findings of this Review report in order to understand whether the Service User experiences detailed within it could be mapped onto present day services. The question should be asked 'are the problems identified with their pathways still a real possibility for other service users today'?**

Recommendation 4: Safeguarding (Adults and Children)

6.18 **Areas Identified for Improvement:** In the case of the service users in this Review both child and adult safeguarding assessment and safety management processes failed. Systems did not join up and partnership working was not evident.

6.19 **Progress Made:** The Trust has been working with its multi-agency partners to strengthen joint working and improve information sharing; the new Trust electronic record system (RiO) is being used to facilitate this. The Trust's Safeguarding Champions Model has been implemented to offer increased levels of guidance and support to practitioners on the front line.

6.20 **Action Required:** Steady progress against the findings and conclusions of this report appears to have been made by the Trust in conjunction with its multi-agency partners. In order to embed new processes, to minimise the risk of child and adult safeguarding issues going undetected and unmanaged, consideration should be given to the following:

1. **Child and adult safeguarding policies and procedures need to be re-aligned between agencies – with particular regard to information sharing protocols.**

2. **In order to promote a culture where robust communication takes place the Trust and its multi-agency partners need to agree how safeguarding alerts should be made without relying so heavily on the use of emails.**

3. **There should be an examination of current safeguarding recording systems across all agencies (education, health, police, probation, Social Services). This to ensure that they align and all alerts and concerns are managed in a synchronised manner.**

4. **Child safeguarding training should be re-visited to also incorporate wellness and child developmental and psychological safety. A multi-agency and multi-disciplinary approach should be taken to this.**

5. **An evaluation of the findings of this report should be considered in order to understand whether the experiences of the service users in this review (and their families) could be mapped onto present-day service provision. The question should be asked 'are the problems identified still a real possibility for other service users and their families today'?**

Category Two: Recommendations Concerning Localised Operational Service Change

Recommendation 5: Basic Building Blocks of Care

6.21 **Areas Identified for Improvement:** This report details numerous areas required for practice-based improvement. These areas include:

- diagnostic practice;
- medication, care and treatment,
- risk management,
- CPA and care planning;
- managing disengagement;
- Service User co-production and partnership.

6.22 The Review findings and conclusions (in keeping with those of the Care Quality Commission in September 2019) focus on the context of poorly performing systems and service provision models. When systems and service models do not align with day-to-day working realities, clinical staff are unduly pressured to work in accordance with good-practice guidance. When this occurs the basic building blocks of care will be compromised; this is the finding of the Review Team.

6.23 **Progress Made:** The Trust has embarked on major care pathway and service reconfiguration developments. This work should in large measure address some of the identified basic building blocks of care issues. However strategic planning can often take several years to embed within frontline service delivery and it should be remembered that the Trust's modernisation programme is part of a five-year strategy not due for completion until 2026.

6.24 **Action Required:** In the here-and-now the Trust should examine the numerous findings contained within this report (and detailed in the Standards Proforma). A mapping exercise should be undertaken to minimise the continued risk of clinical service omissions and the subsequent potential for risk to service users and their families. The following should be undertaken.

1. **A mapping exercise should be undertaken comprising frontline staff and those managers leading the care pathway and transformation agenda. The findings from this Review should be used as a discussion tool in order to assess how practical considerations and frontline service insights can be run alongside high-level strategic thinking and planning. This would also provide an evidence-based progress monitoring opportunity.**

2. **The Trust should review clinical supervision attendance, content, frequency and purpose. Clinical supervision should be aligned to the Trust's clinical audit cycle and have a clear evidence-based focus. Competency-based training and supervision should be available for newly qualified staff and those returning to the workplace after a long break away from the workplace. Clinical supervision should make quite clear the responsibilities of each registered practitioner within the Trust to adhere to best practice policy guidance and how to raise an alert if it is not possible to do so.**

3. **The medical workforce should be provided with clear expectations about conduct, practice and adherence to both NICE guidance and local policy expectation. Expectations should be clarified and built into development and performance management processes. This process should make quite clear the responsibilities of each medical practitioner within the Trust to adhere to best practice policy guidance and how to raise an alert if it is not possible to do so.**

4. **The Trust should review its key clinical policies to ensure they align and that there are no omissions (e.g. safeguarding, clinical**

risk management, CPA and care planning). The Trust should also ensure its policies are easy to read, and where they comprise numerous pages (some are in excess of 80 pages) easy to follow. Flow charts and information leaflets are also be considered for ease of access and reading. The Trust should also ensure that template assessment documents capture all of the information required; especially in the areas of risk and safeguarding.

5. **The Trust should review its 'alert' system so that frontline staff can raise concerns about anything (such as staffing levels, lack of training, ineffective documentation templates etc.) that might inhibit the adherence to either good or safe practice.**

Recommendation 6: Clinical Record Keeping and Professional Communication

6.25 **Areas Identified for Improvement:** Five key areas were identified; they were:

- disparate electronic recording systems (both internal and external to the Trust) that did not 'speak' to each other;
- poor joint working practices that hindered face-to-face planning and professional communication;
- ineffective clinical record templates (particularly risk and safeguarding) which impacted negatively on the recording of accurate information;
- endemic 'cut and paste' practice and a culture of incomplete and inadequate clinical record keeping;
- the need to embed the new Trust clinical record system (RiO).

6.26 **Progress Made:** The introduction of RiO allows for a patient record exchange across all primary and secondary care clinicians across Lancashire; work is also ongoing to share other kinds of information across other electronic systems. This will facilitate continuity of care and joined-up working

6.27 **Action Required:** Whilst progress has been achieved with the introduction of RiO there are still several areas that need to be addressed in order to minimise the risks associated with poor professional communication. The Trust should ensure the points below are incorporated into its transformation agenda.

1. **Discussions should be held with multi-agency partners to see if improved access to Service User information can be facilitated (see recommendations 3 and 4 above).**

2. **Process modeling in relation to practical multi-agency working should be considered as part of the transformation process. An analysis needs to be worked through regarding what multi-agency working actually means in practice and how it can be made to happen in real time on the front line.**

3. **Clinical Information gathering should be re-examined in relation to RiO-based templates, and other Trust-based documentation, to check for compatibility with Trust policy guidance. This should include risk assessment, safeguarding and care planning electronic templates.**

4. **The practice of 'cut and paste' should be strongly discouraged and form part of clinical supervision discussions, clinical audit activity and clinical policy guidance.**

5. **Additional support and training should be provided for those clinicians still struggling to navigate the new RiO system. Checks should also be undertaken to ensure historic information has been reliably transferred from the old system to the new.**

Recommendation 7: Strengthening Trust Audit and Assurance Systems

6.28 **Areas Identified for Improvement:** Trust audit systems have not been sensitive enough to detect non-compliance with Trust policy guidance.

6.29 **Progress Made:** The Trust has been working on its governance agenda since September 2019 following inspection feedback made by the Care Quality Commission (CQC). A recent review was conducted of the Trust's policy and procedural framework to ensure it is fit for purpose. This process has reviewed policies, brought them up-to-date, provided training and aligned guidance with the Trust's clinical audit process.

6.30 **Action Required:** The Review Team recognises the work that has been undertaken by the Trust over a period of years to improve its governance issues. However evidence suggests the organisation would benefit from a regular longitudinal care pathway review of selected cases managed by the Trust; this to understand better how policies and clinical guidance work together in the delivery of care and whether optimal care and treatment is being delivered in an evidence-based manner.

1. **The Trust should conduct a review of selected case studies against the Standards Proforma used for this Investigation (or a bespoke one to address specific issues); this to be conducted as part of an annual audit cycle. This review should take a longitudinal stance and ensure that all systems, policies and clinical guidelines are working together in an optimal manner. This approach will highlight areas for service improvement and provide an early alert to systems that are under stress and not working in an optimal manner.**

Recommendation 8: Internal Incident Investigation Process

6.31 **Areas Identified for Improvement:** During the time-period subject to this Review the Trust was embedding its new investigation process. The

Review Team found reports were still variable in quality and that several areas in the process needed to be strengthened.

6.32 **Progress Made:** The 2019 CQC inspection report criticised the Trust's risk management and learning processes. Consequently the Trust revised its investigation policy and procedures. The Review Team has been to verify that recent investigation reports are increasingly improved and are examples of good practice.

6.33 **Action Required:** While the embedding process continues the Trust should consider monitoring its current practice on a regular basis and should ensure the following:

1. **Terms of Reference are written on a case-by-case basis to ensure the basic building blocks of care are always reviewed as part of a quality assurance process.**
2. **Investigations should be supported by suitably skilled and trained staff who have protected time to complete the work.**
3. **Detailed investigation archives should be kept on a centralised Trust system designed for this purpose.**
4. **Treating Teams should have the opportunity to be interviewed and/or met with whenever possible during the course of an investigation. Emphasis should be placed on good investigation principles that support Trust staff to ensure their full engagement and maximise opportunities for learning. Recommendations should be developed with treating teams to ensure they are both relevant and achievable.**
5. **Duty of Candour principles and guidance should be made explicit in the Trust's investigation policy guidance.**

Glossary

Antipsychotic medication	Antipsychotics are a range of medications that are used for some types of mental distress or disorder - mainly schizophrenia 1 and bipolar disorder 2 (sometimes called manic depression). They can also be used to help anxiety or depression 3 where it is severe or difficult to treat.
GP/Primary Care Services	General practitioner: a person who provides general medical care. Primary care services provide the first point of contact in the healthcare system, acting as the ‘front door’ of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
Multi-Agency Risk Assessment Conferences (MARAC)	A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), Probation and other specialists from the statutory and voluntary sectors.
Multi-Agency Public Protection Arrangements (MAPPA)	MAPPA stands for Multi-Agency Public Protection Arrangements. It is the set of arrangements through which the Police, Probation and Prison Services work together with other agencies (such as NHS Trusts) to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.
National Institute of Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care. In April 2013 NICE was established in primary legislation, becoming a Non Departmental Public Body (NDPB). As an NDPB, NICE is accountable to its sponsor department, the Department of Health, but operationally it is independent of Government. Its guidance and other recommendations are made by independent committees. The way NICE was established in legislation means that its guidance is officially England-only. However, it has agreements to provide

certain NICE products and services to Wales, Scotland and Northern Ireland.

Appendix 1

Terms of Reference
Thematic Pathway Review

The Terms of Reference for the Thematic Pathway Review are set by NHS England and NHS Improvement. These Terms of Reference will be developed further in collaboration with the investigative supplier and stakeholders.

Thematic Pathway Review

Background

A Clinical Commissioning Group and NHS England and NHS Improvement identified a number of recurring themes in the serious incidents reported by the Trust 2015 and 2020. The issues identified are:

- Quality of internal investigations including engagement with affected families post incident.
- Risk Assessment and Care Planning (including Service User non-engagement)
- Dual Diagnosis.
- Communication issues (internal and external).

Following initial discussion between the CCG, NHS England and NHS Improvement and discussion with the Trust it was agreed to commission an independent review of these recurring themes. The review will consider five cases reported between January 2019 and November 2020.

The independent investigators will conduct a quality review to consider the service provision at the time of the incidents and examine the learning/improvements that have subsequently taken place and offer an opportunity to develop a supporting action plan.

It will ask the fundamental question of:

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

The Review will:

- Carry out a review of agreed services/pathway with reference to these issues.
- Review the development of the present-day service provision, governance and quality systems, arrangements for identifying and escalating risks and opportunities for improving the quality of services.
- Review and assess compliance with local policies, national guidance and statutory obligations.
- Review an agreed sample of patients’ journeys through their individual pathways.
- Facilitate a workshop(s) with staff from the services to examine in detail the pathway from beginning to end

- The review process should also identify areas of good practice, opportunities for learning and areas where improvements to services may be required.
- Provide a written report to NHS England and NHS Improvement that includes agreed, measurable and sustainable outcome focussed recommendations.
- Support the formulation of an overarching action plan with providers and commissioners and agree reporting structures.
- Develop in collaboration with the ICS/NHS E/I an assurance review process to support the collection of evidence and measurement of data to demonstrate the implementation, sustainability and embeddedness of all recommendations.
- Produce an anonymised learning document, suitable for sharing with other providers, on the learning from this process.

APPENDIX 2

DUNCAN &
JOHNSTONE
Investigation, Learning, Improvement

Duncan and Johnstone Consultancy Ltd

Thematic Pathway Review Proforma & Quality Standards

Aggregated Data

2022

The standards are based upon local and national best practice guidance. This ensures:

- **an objective evidence-based approach to the work;**
- **a structured way in which to identify specific gaps or good practice in service;**
- **an audit tool for future assurance and monitoring purposes.**

The evidence set out in the Review Proforma was taken from a documentary analysis of the clinical records of the five Service Users selected for the Review.

Background

In January 2021 D&J was commissioned by NHS E/I to conduct a care pathway review to examine key re-emerging themes that arose from the investigation of some 30 homicides and serious non-fatal assaults perpetrated by services users receiving care and treatment from the Trust.

D&J were asked to examine five cases in depth in order to understand better the re-emerging themes. A comprehensive analysis of the clinical records and other archive documentation was undertaken and a chronology and review proforma developed for each of the five Service Users in the study. A detailed and targeted approach has been taken in order to understand exactly where on the care pathway service could be improved together with an understanding of general policy and good practice compliance. The Thematic Pathway Review is not an investigation process but a systems analysis process with a focus on learning and service improvement. NB: the purpose of the Thematic Pathway Review is not to reach conclusions about the predictability or preventability of the incidents that occurred due to any acts or omissions of service.

Challenges to Completing the Review Proforma

The Thematic Pathway Review has been in essence a desktop exercise largely dependent on the analysis of clinical records. The clinical records that have been provided are concise in nature with significant omissions relating to the customary documents both local and national policy guidance require (risk assessments, CPA reviews, care plans etc.). After liaison with the Trust D&J understands it is in receipt of five complete sets of clinical records – however during the course of the review it was evident that Trust record-keeping systems are complex and it is entirely probable that ‘incomplete’ sets of records have been worked with due to ongoing access and retrieval issues. In the interests of fairness assessment has been withheld against some standards where it is possible an incorrect or unhelpful rating could be given.

The gradings have been used as follows:

The D&J Review Team has graded the standards as set out below. The decision to set gradings has sometimes been difficult – however the key decision factor (when margins are too close to call) has been whether or not the spirit of the policy guidance has, or has not, been met.

Key:

✓ The standard has been met consistently over time for all five Service Users demonstrating a reliable and systematic adherence to policy guidance. **NB:** it would be impossible for standards to be met 100% of the time over periods of several years – a judgement has been made indicating that practice is compliant most of the time so some leeway has been given.

✓ The standard has been met partially over time. Sometimes the standard has been met partially for all five Service Users, sometimes the standard has been met in full for some Service Users and not for others (the individual Service User proformas detail how a grade has been given).

X The standard has not been met – or is substantially unmet. This grade is given when it is evident that there is a significant and consistent departure from policy guidance over a period of time.

? There is not enough evidence to assess the standard. This grade is given when there are significant gaps in the clinical record that might be due to a Trust access and retrieval issue when sending records to D&J rather than an omission in care and treatment practice. In the interests of fairness an '?' is given if there is reasonable doubt.

- This means that the standard was not relevant to the case under review.

Quality Standard	**Met:** ✓ **Partially Met:** ✓ **Unmet:** ✗	**Evidence Drawn from the Review** (comments may include a robust appraisal of the criteria, and may include any unusual or atypical circumstances relating to the item)
Themes from Internal Trust Thematic Reviews and Confirmed by the Independent Review Process		
1. Diagnostic Practice and Missed Psychosis/ Substance Misuse/Dual Diagnosis		
Diagnostic Process and Formulation ▪ A full and relevant history is taken.	✓	This standard was variable across the 5 cases. It was met in full in 2 cases, inadequately in 1 case, and was partially met in 2

		cases (of these 2 cases: 1 was recorded in inpatient settings only – 1 was recorded historically but does not seem to have been used/or was accessible to other services from that date).
▪ Comprehensive mental state examinations are undertaken and recorded.	✓	This standard was variable across the 5 cases. It was met in full in 1 case, but was variable in the other 4 cases. Clinical records were at times overly concise and did not state whether key assessment data was a formal MSE. MSE's were not always conducted as part of diagnostic assessment or when presentation changed. In one case MSE's appeared to be robust until 2014 – and then no further assessments were recorded until the time of the incident 5 years later. It is possible assessments did occur and were either not recorded – or could not be retrieved by the Trust for the D&J review.
▪ In making the diagnosis and differential diagnosis psychiatrists use a widely accepted diagnostic system.	✓	This standard was met clearly and unambiguously in 2 cases. The other 3 cases (whilst sometimes listing ICD10 codes) offered no narrative or explanation as to the diagnoses reached – with all 3 of these cases several diagnoses would often be recorded running alongside each other with no consistent diagnosis or formulation being offered – diagnostic ambiguity often remained for several years.
▪ Service Users and their carers are worked with in partnership during the assessment process.	✓	This standard was met in 3 cases. The 2 other cases were affected by a breakdown in the therapeutic relationship – in part due to ongoing diagnostic ambiguity and differences of opinion between the treating team, the Service Users and their carers.
▪ Psychiatrists seek (and consider) advice, assistance or a second opinion if there are uncertainties in diagnosis and management or if there is conflict between the clinical team and the patient and/or their carer and family regarding diagnosis.	✓	The standard was met in 1 case – and was NAD for another. The remaining 3 cases were retained by the treating teams (even though quite complex) when referral/second opinion might have benefitted – referrals were made in one case – but it is not clear what happened to them – they do not appear to have been

		actioned/followed up.
▪ The reasoning behind clinical assessments/decisions is explained and written in the record. If appropriate an account of alternative plans considered but not implemented is recorded.	✓	This standard was met in 1 case. The other 4 cases all have overly concise clinical records which made it difficult to understand the rationale behind assessment, decision making and planning.
▪ The ethos of co-production with Service Users and their families is both promoted and maintained.	✓	This standard was met in 2 of the 5 cases. Out of the 3 remaining cases 1 was partially met (but an overly concise clinical record made it difficult to understand how the process worked); the remaining 2 cases did not meet the standard with a loss of trust and confidence on the part of families and service users.
▪ The Service User's right to a second opinion is respected and supported.	✓	4 out of the 5 Service Users in the review did not ask for a second opinion. The Service User that did had to wait several years before his request was actioned. It would appear that the second opinion was provided without a face-to-face interview with the Service User – this led to a loss of trust and confidence on the part of the Service User and his family.
▪ Risk assessments and care plans take full account of diagnostic formulation when designing and assigning the required pathway.	X	This standard was not met across all 5 cases. Risk assessment was of a general poor standard and not conducted on a regular basis – the 5P's appear to have been a tick box exercise and was not linked with a proper diagnostic formulation. Risk assessment appears to have been uni-professional and it was not possible to see where the diagnostic inputs came from or how they were overseen and supported by a consultant psychiatrist.
▪ Referrals are made/advice sought to/from specialist colleagues (i.e. to forensic psychiatry, dual diagnosis services) to seek further opinions if service users have multiple aspects to diagnosis/formulation.	✓	Out of the 5 cases 1 met the standard and 1 was NAD. Of the remaining 3 cases 1 totally failed to meet the standard and the remaining 2 cases had the standard partially met. A common feature was the tendency to 'hold on to' to the case for an overly

		long period (perhaps a year or two) before referring to specialist services. During this time the Service User's situation continued to deteriorate and made a contribution towards aspects of the care and treatment not being as effective as it perhaps could have been. Opinions and specialist referral were difficult to track due to an overly concise clinical record.
Issues for further consideration 1. What are the audit processes deployed by the Trust to ensure medical practice meets the above standards? **Summary:** These standards were relatively difficult to assess due to an overly concise clinical record. D&J cannot be certain that all of the records have been sent to the Review Team. If the extant record has been sent in its entirely then the processes of follow up, communication and planned care and treatment is below the required standards set both by the Trust and professional bodies. The practice relating to psychiatric history taking, the recording of MSEs, and diagnostic formulation is variable – but on the whole this appears to be an area that requires improvement. It was difficult for the Review Team to follow the clinical thinking and how this impacted upon long-term care and treatment. The overriding concern is that the effective and safe continuity of patient care could be compromised through current practice. There appears to be a prolonged period of time taken to come to a diagnosis (sometimes 3 or 4 years). A notable feature is that some Service Users 'collected' multiple diagnoses depending on which team they were currently under (sometimes five or six different diagnoses were offered). The clustering tool served to add an additional layer of complexity – often citing diagnoses and pathway criteria that were at odds with other documentation (e.g. letters to GPs, referral letters, CPA etc). The lack of providing a diagnosis/differential diagnosis made the use of the clustering tool problematic as it was not clear which pathway a Service User should be on and which care cluster they belonged to. This also impacted on medication choices (e.g. antipsychotics prescribed for service users who were recorded as not being psychotic) and on occasions the therapy model chosen.		
2. Clinical Risk Management		
Policy - There is a systematic approach to risk assessment and management in relation to violence, self harm/suicide and self neglect.	X	This standard was not met across all five cases. Risk assessments were often few and far between – they did not synchronise with CPA reviews, changes in Service User presentation or the high levels of risk (violence, self neglect and suicide) as recorded in the day-to-day Contact Notes. Risk appears to have been managed in a reactive manner – there

▪ Training and support are provided (in keeping with the Trust policy to ensure adherence). ▪ Supervision provides regular scrutiny of clinical assessment and management plans (in keeping with the Trust policy to ensure adherence). ▪ Network Governance Groups provide regular monitoring and assurance that the Trust risk policy is adhered to (in keeping with the Trust policy to ensure adherence).	**?** **?** **?**	were no robust risk management plans found within the case notes.
Risk assessment **In General** ▪ Any new information gained which highlights any previously unidentified risk, or escalation of known risk, results in a further formal risk assessment being documented.	**X**	This standard was substantially unmet. New information as provided by referrers, the Contact Notes, carers etc. did not inform risk assessment documentation for these 5 cases. 3 of the cases had either a single risk assessment on file despite high levels of risk being recorded in the Contact Notes; changes in presentation and CPA processes did not appear to trigger a risk assessment when indicated. It was not possible to understand where the précised risk statements (often single sentences) in the Contact Notes came from or how they were derived.
▪ A formal risk assessment is completed and recorded at initial assessment. On-going risk assessments are conducted for all Service Users and inform the care planning process.	**X**	This standard was substantially unmet. For 3 of the cases there was a single assessment (one consisting of a single page – despite care and treatment being delivered over a period of many years). Where risk assessments were developed there were gaps in the record, a high degree of cut and paste (perpetuating errors over time in some cases). Assessment did not lead to substantive risk management plans – plans if they did exist consisted of a single sentence or a few words – it was difficult to understand how the assessment process (when one had taken place) lessened or mitigated risk.
▪ Risk assessments are discussed with the wider care team	**X**	This standard was substantially unmet. There is very little

and actions agreed to manage/minimise identified risks. This is recorded in the care plan.		recorded in the clinical records – risks were recorded – but usually not in a risk assessment format – risks were usually communicated and recorded in a reactive manner once a specific intervention was required (usually at the point of crisis). Apart from domiciliary visits and inpatient admission there was usually no kind of action listed – actions can't really be identified as 'plans' as they are outside of a formal risk assessment process – care plans were not usually found to address risk – although on rare occasions risk is mentioned.
▪ A consultant psychiatrist is directly involved in clinical decision making.	✓	This was variable across the 5 cases. The standard was met in 1 case, and partially met in another. Whilst it was evident consultant psychiatrist's were involved in some decision making (medication, inpatient admission, discharge) the paucity of the clinical record made it difficult to see to what extent they were actually involved in developing and overseeing a coherent care and treatment plan. In relation to risk assessment it was not possible to understand how psychiatrist input was made as the risk assessment process appears to have been uni-professional in nature.
Standard Risk Tool ▪ Practitioners assess the likelihood of harm to self or others as part of an overall assessment of need.	✓	This standard was partially met – gaps in the clinical records made it impossible to assess for 1 case. A 'tick box' approach was usual in the other cases – infrequent assessment – gaps over long periods of time in the clinical record – with assessment data not always being in synchronisation with the narrative/presentation as detailed in the Contact Notes.
▪ Practitioners identify any current or historical risks on the three clinical risk domains; risk to self; risk to others; vulnerability (and domestic violence added to the 2021 policy).	✓	There were significant gaps in the documentation which made this standard difficult to assess. Risk was not always listed in keeping with the narrative of the Contact Notes. It was not possible to understand which tool was supposed to be used and often there was only a single risk assessment on file (representing all risk documentation whether standard or

		enhanced was indicated) covering a span of several years despite significant risks being recorded in the Contact Notes.
- The practitioner completes a Risk Formulation and Risk Management Plan.	X	This standard was substantially unmet. There are significant gaps in the clinical records making it uncertain whether the Trust has been able to access the records for the D&J review. The risk documentation that was available was largely 'tick box' or 'cut and paste' from earlier out-of-date assessments with no risk management plans (apart from single-sentence plans for a couple of the assessments). For 3 of the cases formal risk assessment documentation was almost entirely absent even though significant risks were recorded in the Contact Notes. Clinical interventions appear to be reactive when Service Users were in crisis. The 5P formulation tool was used but this was formulaic and made no contribution to risk mitigation.
- When risk areas are identified consideration is given to the management of these risks and input from other teams within LCFT is sought if required.	X	This standard was substantially unmet. There are significant gaps in the documentation making it difficult to assess. Recorded referrals are rare across all 5 cases – when referrals did take place it was not possible to understand whether they were accepted or not.
Enhanced Tool: - Risk assessment selects the risk behaviours and factors for harm to self, harm to others and vulnerability.	X	This standard was substantially unmet. 4 of the 5 cases had no enhanced risk documentation on file even though the Service Users were under CPA for much of the time and had high risk profiles. Key events and changes to presentation did not trigger a formal risk review. In the single case where the enhanced risk tool was used it was evident that there was a high degree of cut and paste – this meant that current issues and changes to presentation were not assessed properly. Plans were not reviewed and did not tend to change over time regardless of presentation or changes to clinical context.

▪ The practitioner articulates the nature of the risk/s including the behaviours, characteristics and context and completes a formulation.	X	This standard was substantially unmet (see the section directly above). Some formulations were provided – but they appear to have been from a cut and paste process and not in keeping with the ethos of the Trust policy guidance; the level of analysis was superficial.
▪ Risk formulation summarises and documents the types of risks and to whom, what escalates or decreases the risk, how imminent, serious and volatile the risk is, what strategies can reduce the risk and how effective the management plan will be.	X	This standard was substantially unmet – the paucity of the clinical record made it difficult to assess all 5 cases. In the cases where the enhanced assessment tool was used the cut and paste method meant that current risks were often subsumed in past issues and not mentioned. The risk assessments did not address the dynamic presentation of risk as detailed in the Contact Notes. Management plans were often single sentences - there was no discussion or rationale provided for the approach taken which was over simplistic and lacking in detail.
▪ The risk assessment is reviewed and updated in accordance with the care programme approach policy, mental health clustering guidelines, other related procedural documents and the service's standard operating procedures.	X	This standard was substantially unmet (see the section directly above). In the cases where the enhanced tool was used (and in 1 case in particular) high levels of risk as recorded in Health and Social Needs Assessments/Contact Notes were not brought together in a risk assessment document. Actions to manage risk appears to have been reactive – and not the consequence of clearly documented plan. Cut and paste documents contained erroneous, misleading and out of date information – assessments were not always reviewed in keeping with the CPA policy or when Service Users reached key milestones on their Care Pathways (e.g. discharge).
5P Formulation model ▪ The 5P formulation model is used.	X	This standard was substantially unmet. The lack of clinical records made the standard difficult to assess. Where the 5P formulation was used it appears to have been a 'tick box' process that did not adhere to the ethos of the 5P process in that risks were not assessed and considered in a robust manner (see

		section above)
- Risk assessments are holistic and comprehensive.	X	This standard was substantially unmet for the same reasons as already set out in the sections immediately above. When the enhanced tool was used it was apparent that assessments appeared to be holistic and comprehensive on first view – but over the years the risk assessments were largely cut and paste – around 90% of the assessment remained the same – it was not dynamic – and was often incorrect. Formulation was largely descriptive rather than providing an analysis of risk factors in the round. Issues such as psychosis, substance misuse and risk to others were not addressed in meaningful way – current lifestyle factors and mental health issues were not brought together into a proper formulation of risk.
Risk Planning - Clear plans (with specific actions) are developed to mitigate the risks identified.	X	This standard was substantially unmet. The paucity of the clinical record made it difficult to assess for 3 of the cases under review. The remaining 2 cases had overly simplistic risk management plans. In 1 case plans consisted of the decisions to ‘admit’ ‘detain’ or ‘discharge’. In the other case plans were often simple lists that had a fragile link to the known levels of risk.
- Risks and risk management plans are communicated to all relevant stakeholders (other services, GP, carers etc.).	✓	This standard was partially met. The paucity of the clinical record made it difficult to assess for 4 of the cases under review – however it is evident that other supporting records (such as letters to GPs, CPA documentation) did not take the opportunity to share risk. In a single case other stakeholders were warned not to see the Service User on a 1:1 basis following an altercation during a CPA meeting – however other serious and ongoing risks do not appear to have been shared. It is evident that conversations were sometimes held with relevant stakeholders – but there did not appear to be any resulting plans developed.

▪ Plans are updated when risk profile alters.	X	This standard was substantially unmet. 3 of the cases under review had virtually no documentation spanning an average period of 5 years with service. 2 of the cases were partially compliant with the standard – but plans consisted of single sentences or (in the case of 1 service user) focused on a very particular risk which did not allow for other significant risks to carers, children and the general public to be addressed.
▪ Plans are updated in keeping with policy guidance.	X	This standard was not met for reasons already set out in the sections above.
▪ Positive risk management is part of carefully constructed plans.	X	This standard was not met. In a single case positive risk taking was cited in the internal investigation report – but this was not recorded in the Service User's contemporaneous clinical notes.
▪ Named practitioners/services are set against specific actions/interventions.	✓	This standard was partially met in 2 cases. It should be noted that actions in relation to risk management were few – but named practitioners were sometimes identified.
Crisis and Contingency Planning ▪ Robust relapse and crisis plans are developed providing clear instruction for the service user, carer and treating team.	✓	This standard was partially met in 3 cases and unmet in 2. In 1 of the 3 cases A&E was cited as being the crisis plan – in another case 4 crisis plans were on file for a 5 year period (but don't appear to have been updated), the last case had some crisis plans in CPA documentation – but it is not clear whether carers or the Service User had copies of them – neither was it clear if the GP had been notified. The plans were weak and did not provide clear guidance.
The Protection of Children ▪ The needs of children are paramount at all times and the Think Family Approach is considered during every risk assessment and planning process.	X	This standard was not met. In 2 cases the standard was NAD – for the other 3 cases it was a significant issue. ▪ In the first of the 3 relevant cases the Service User was himself a child for the majority of his time with service – there was proven sexual abuse/substance misuse and contact with Social Services – this aspect was not discussed or examined

		in risk assessment documentation (or anywhere else in the clinical record to the extent to be expected). This Service User also had a sister living at home – there is no age recorded for her or safeguarding issues considered/recorded. - In the second of the 3 relevant cases the Service User's children were listed as being protective factors – it was known Social Services were involved on occasions – however there is scant record of this. Risk assessments do not list risks to the children – there are no care plans – even though the Service User was on license and subject to MAPPA (for a considerable of period of time whilst with service), psychotic, and regularly misused drugs and alcohol. - In the third of the 3 relevant cases children were listed as protective factors – but despite an extensive forensic record for violence (and being on license for a considerable period of the time he was with service) no consideration was given to the children – the single exception was in the days prior to the incident when a concern was raised – however the Service User's contact with children had been known (and went unaddressed) for at least 9 years before this.
- The impact of substance misuse or alcohol use is considered in relation to child safety and wellbeing.	X	This standard was not met. Substance and alcohol misuse was a significant factor in 3 of the cases under review. This was not considered in relation to child safety and wellbeing.
Multidisciplinary working - Risk assessment is developed in conjunction with the whole multidisciplinary team.	✓	This standard was partially met. In 2 cases it was not met – in 1 case there was not enough documentation to assess the standard, in 1 case the standard was partially met (in relation to a specific risk factor), and in 1 case the standard was met.
- Managers and team leaders initiate and review risk assessments and management plans.	?	There was not enough evidence to assess this standard. There was no evidence in the clinical records viewed to suggest this occurred. On one occasion a Manager was asked to write a letter to a Service User to state aggressive behaviour would not

		be tolerated – but that is the single example of Manager input to be found.
Multi-agency/Inter-Service working - Risk assessments and plans are shared with all Trust services involved with the Service User.	X	This standard was substantially unmet. There were risk assessments on file for 2 cases, insufficient documentation to assess for 2 cases, and a partial compliance for 1 case. Other documentation sometimes contained risk information but in an overly concise form (e.g. referral documentation) which by its very nature was designed to be shared with other services. There was no evidence to detail how assessments and plans (such as they were) were shared.
- When appropriate risk assessment is developed in a multi-agency manner.	✓	This standard was partially met across 4 cases – with insufficient documentation to assess the fifth case.
- Risk assessments are shared with multi-agency partners.	X	This standard was partially met. In 3 the standard was partially met; in 1 case the standard was not met. In 1 case it was NAD. In one of the partially met cases the shared risk documentation had been prepared by Probation Services – this document then went on (in a largely cut and paste version) to be used relatively unchanged over the next 4/5 years. Whilst meetings were sometimes held with multi-agency partners documented risk assessments were not.
- General Practice is notified of all relevant risk assessments and management plans.	X	This standard was substantially unmet. There was insufficient documentation available to assess the standard for 3 cases. In 1 case ‘condensed’ risk information was sometimes shared, in the remaining case the GP was notified on one occasion that 1:1 working with the Service User was not advised.
Service User and Carer Involvement - Service Users are involved in risk assessment, planning and management whenever possible.	✓	A single Service User had this standard consistently met over time. There were significant gaps in the clinical records which meant the standard could not be assessed for 1 Service User. The remaining 3 Service Users were not involved in risk

		assessment or planning – even though 1 of the individuals repeatedly tried to talk about his perceived level of risk and his anxieties in relation to harming others.
▪ Carers are involved in risk assessment, planning and management whenever possible.	✓	A single Service User had this standard met consistently over time. There were significant gaps in the clinical record which meant the standard could not be assessed for 1 Service User. The remaining 3 cases did not have this standard met – carers were left to voice concerns in a reactive manner (and were sometimes dismissed abruptly by service). One carer repeatedly discussed concerns about her own safety – whilst these concerns were recorded – they did not form part of a risk management plan – in the event the carer left the family home to maintain her own safety and that of her child.
▪ Carers are able to escalate concerns.	✓	A single Service User had this standard met consistently over time. There were significant gaps in the clinical record which meant the standard could not be assessed for 1 Service User. 1 Service User did not have this standard met – the other 2 Service Users had this standard partially met. The main issue was that carers often voiced concerns – these concerns were documented – but they did not alter risk assessments or management plans – it would appear that carers were often frustrated by the lack of response – most concerns were raised when the Service User was already in crisis as there was no proactive early warning/escalation plan.
▪ Carers at risk are informed by practitioners and supported in keeping safe.	✓	A single Service User had this standard met consistently over time. There were significant gaps in the clinical record which meant the standard could not be assessed for 2 Service Users. The remaining 2 Service Users did not have this standard met. Carers did not appear privy to the concerns held by the treating team – and no measures appear to have been put in place to keep them safe.

Issues for further consideration

1. There appears to be little clarity as to whether a standard assessment tool or an enhanced assessment tool is used within policy guidance – neither does there appear to be any written rationale provided in the clinical record for selecting one tool over another.
2. There is no specific instruction in the risk assessment documentation (the actual assessment tool itself) regarding children as would be usual in risk management processes – these might need to be more specific and focus on wellbeing as well as risk. The risk assessment, CPA and safeguarding policies do not provide a coordinated approach to safeguarding and the assessment documentation does not provide sufficient instruction and guidance.
3. There are no formal/transparent links with safeguarding processes.

Summary: It has been difficult to understand how the risk management process worked across the 5 cases due to the overly concise nature of the clinical records.

What is apparent is that risk and diagnostic formulation is not conducted against local or national policy guidance in that the different strands of diagnoses and risk presentation are not brought together in a meaningful way in order to understand the levels of risk incurred. The 5P formulation process appears to be undertaken by care coordinators – it is not evident whether the 5P formulation process is developed formally as part of a multi-professional team discussion – it would appear not. The 5P formulation comes across as being a ‘tick box’ exercise. There is a disconnect between the contact notes and the risk assessments that are on file. Risk management in reality appears to have been a reactive response to the Service User’s presentation and/or reaching a point of crisis. Risk management planning was either non-existent or so superficial it could not provide proactive guidance for the Service User, the carer or the service in managing or mitigating risk.

A key concern is the lack of multi-agency risk assessment and planning (of particular relevance for those Service Users on license/MAPPA, and for those whose risk behaviours put others – especially children at risk). Information sharing is virtually absent in the clinical records viewed. This lack of coordination made access to care and treatment problematic for Service Users (and their carers) as they were sometimes noted to have 3 care coordinators at any one time (from different agencies) and did not always know which service/agency was supposed to be supporting them with what. Service Users also had to undergo repetitive assessments – this took up a great deal of time, and for at least 1 Service User was both exhausting and confusing. Each agency appears to have been focused on meeting the requirements of its own service – but these levels of activity did not always equate to meaningful engagement with the Service User and appear to have been run in parallel rather than in synchronisation.

3. CPA, Care Planning and Care Coordination

CPA Process ▪ Corporate assurance and oversight procedures are in place to monitor policy adherence. ▪ Service managers and modern matrons ensure policy adherence via management supervision. ▪ All staff receive face-to-face training.	**?** **?** **?**	The Trust provides some information for these 3 standards in the body of the report.

▪ All Service Users on CPA are allocated a care coordinator and the care plan identifies the care coordinator and consultant psychiatrist.	✓	This standard was substantially met. However it should be noted that 1 Service User had 3 care coordinators listed as being active at the same time from different agencies – this is perhaps an unusual situation – problematic in that there did not seem to have been robust information sharing between them.
Eligibility Criteria ▪ The eligibility criteria for CPA (in accordance with Trust policy) are adhered to (risk of suicide, self- harm, harm to others - including history of offending - relapse history requiring urgent response, self-neglect/non concordance with treatment plan, vulnerable adult; adult/child protection, multiple service/agency provision).	✓	This standard was partially met with all 5 cases. However each Service User was often discharged from CPA when they still met the criteria. It remains unclear why discharge went ahead when the Service Users still posed high levels of risk (either to themselves or others), suffered a severe and enduring mental illness, and were often open to multiple other agencies and/or services. In 2 cases discharge from CPA took place as a response to non-attendance at review meetings/failure to attend appointments.
Assessment ▪ Care plans are informed by the risk assessment process.	X	This standard was substantially unmet. For 3 Service Users this standard was not met. In the remaining 2 cases it was partially met – however it was evident that care plans did not address the risk assessment process in the spirit of the Trust policy guidance – risk assessments were usually 'cut and paste' and out of date – care plans did not address current risk appropriately.
▪ Assessment is holistic and multidisciplinary in nature.	✓	This standard was partially met. However across all 5 cases it is difficult to see how medical/psychiatrist assessment was inputted. Assessment focused primarily on a standard 'activities of daily living format' – the key input appears to have been from a nurse/care coordinator. There are infrequent OT assessments for 2 of the Service Users in the review – none for the others. Care Plans do not always address the key issues raised in the contact notes and assessment does not appear to be either multidisciplinary or dynamic in nature. The exception to this was when Service Users were inpatients.

▪ Assessments include reference to risk, safeguarding, parenting/caring roles, and carer involvement.	✓	This standard was partially met across 3 cases and not met for the remaining 2. A common feature was the absence of risk assessment. In the 2 cases where the standard was partially met safeguarding and carer involvement were virtually absent despite significant issues recorded on a regular basis in the Contact Notes. There was also a 'tick box' approach taken on frequent occasions with repetitive assessments over time not in keeping with current presentation.
▪ All staff involved in the Service User's care contribute towards assessment and formulation. The views and aspirations of the person being assessed are also recorded.	✓	This standard was partially met across 4 cases with insufficient documentation to assess the fifth case. The clinical records show that assessment and formulation were routinely conducted by single teams and/or professionals – even when several services were involved. Full MDT inputs were usually confined to CPA reviews – these were infrequent (and for those not on CPA not held). Service User input was variable over time – care plans were often written in the first person – but it is evident that service users often refused a copy and the contact notes suggest distinct differences of opinion between Service Users and treating teams on occasions (often not taken into account on the assessment or formulation documentation).
▪ Risks to children and vulnerable adults form part of the risk assessment and appropriate advice sought and referrals made in line with the safeguarding policy and procedures.	✓	This standard was partially met. It was unmet in 2 cases, partially met in 2 cases and was NAD for the fifth case. Safeguarding was sporadic and largely 'tick box' in approach. Referrals were not always made in line with the safeguarding policy. It should be noted that safeguarding referrals were merited on frequent occasions but were not made.
▪ A comprehensive multidisciplinary assessment of the Service User's health and social care needs (including any risks they may face) is undertaken collaboratively with them, their carers and any partner agencies. Assessments are ongoing and require continued	✓	This standard was partially met across 4 cases and not met for 1. Inpatient assessment was usually robust, comprehensive and multidisciplinary in nature. Multi-agency working appears to have been weak (both in inpatient and community contexts) as it is rarely referenced within the clinical records even when several

monitoring for any changes required. Where possible other agency's assessments will be combined.		other agencies were involved (e.g. Social Services, Probation etc.). Service User and carer inputs are variable across the cases over time – assessments were not always dynamic and alterations in presentation (as voiced by Service Users and their carers) did not always trigger fresh assessment.
Care Planning		
▪ The care plan includes plans to support parenting or caring roles for children and vulnerable adults.	X	This standard was not met for 3 cases and was NAD for 2.
▪ All Service Users are encouraged to be involved in the development of their care plan which is recovery focused. The assessment identifies the person's aspirations and strengths as well as their needs.	✓	This standard was partially met across all 5 cases. Service Users were worked with but it is evident that there was also a refusal on the part Service Users to accept copies of care plans on many occasions – this suggests a potential degree of disengagement or disagreement. Care plans were often 'cut and paste' and focused on immediate presentation rather than recovery and long-term wellness.
▪ Where Service Users are prescribed medication for mental health problems it is identified as part of the care plan who prescribes the medication, where it is obtained from, the instructions for its administration, the desired effects, the potential side effects and how these will be monitored. The care plan must include what other medications are being prescribed for physical health problems.	✓	This standard was partially met. It was met in full in 1 case, partially met in 2 cases, and was not met in 2 cases. Medication was not found to be routinely mentioned in care plans. 1 Service User had regular and ongoing issues in accessing medication whilst in the community. Monitoring is not always mentioned in care plans and it would appear that the GPs were asked to monitor ongoing health issues (as would be usual); however it is not clear how this communication was maintained.
▪ A crisis plan is developed.	✓	This standard was partially met. It was unmet in 3 cases and partially met in 1, and met in full in 1. Crisis plans are either absent within the clinical record or provided a simple list of numbers to call – there is no instruction or guidance for carers – interventions tend to be reactive and not always based on relapse signatures.
▪ In keeping with the CMHT OP - All Service Users have	✓	This standard was partially met in 4 cases – it was NAD for 1 as

the opportunity to draw up a plan of care, written alongside their care coordinator and carers where appropriate, that describes their relapse signatures and action to be undertaken.		the Service User was not open to CMHT services (although with a differential diagnosis of Paranoid Schizophrenia he perhaps should have been). There is evidence to support Service User involvement – but carer involvement was limited (of particular concern as one of the Service Users was a child for the majority of his time with the Trust). Relapse signatures appear infrequently – and often are not mentioned in care plans.
Review and Discharge ▪ All Service Users have a formal review with their care team, including their consultant psychiatrist, at least 12 monthly. This focuses on the effectiveness of the care plan. An earlier review is held should there be a significant change in the service user's presentation, transfer of care arrangements between teams or service areas and in accordance with Mental Health Clustering Review guidelines.	✓	This standard was partially met. CPA reviews/reviews appear to have been held at least annually. However reviews were not triggered by changes to presentation (as evidenced by the contact notes). Reviews did not always appear to impact upon the care plans developed – clustering did not appear to alter/focus service provision.
▪ The decision to discharge from CPA is agreed within a CPA review.	✓	This standard was partially met. Decisions to discharge appear to have been made during CPA reviews – although overly concise documentation makes this difficult to track on occasions.
▪ Discharge is discussed with the Service User and any carers involved.	✓	This standard was partially met for 2 cases, met for 2 cases and was NAD for 1 case (Service User not on CPA). The decision to discharge from CPA was usually discussed with the Service User (although not so often with carers). On 2 occasions Service Users were discharged for non-attendance at CPA meetings and the decision not discussed with them.
▪ The reasons for discharge are clear and conveyed to the Service User and their views sought. When planning discharge, consideration is given to any on-going care/support required and possible future involvement with services. The Service User and GP are given a copy of the discharge care plan which details	✓	This standard was unmet for 1 case, met in full for 1 case, was unable to assess for 1 case (due to an absence of documentation), was partially met for 1 case and was NAD for 1 case (not on CPA). Documentation was at times overly concise (or absent) making this standard difficult to assess. Ongoing care plans were often superficial given Service User history and

advice/information about how to access the service in the future and relapse prevention strategies.		presentation on discharge – no evidence to suggest GPs were sent copies of care plans – relapse signatures and advice for future access to service was sporadic and largely absent.
▪ Recovery is the focus of all mental health interventions and discharge from services is planned in partnership with the individual and carer (where appropriate) at their initial assessment and reviewed regularly.	✓	This standard was partially met. It was unmet in 2 cases, met in full in 1 case, was partially met in 1 case and was NAD for 1 case (not on CPA). Planning in partnership only occurred in 1 case – however recovery did not appear to be a strong focus in general.
Service User Involvement		
▪ Service Users are involved throughout assessment and planning stages.	✓	This standard was partially met in 3 cases and met in full in 2 cases. However it is difficult to understand how engaged service users were – care plans were often written in the first person – suggesting a high degree of involvement and agreement – but this appears to be a Trust stylistic issue rather than an indication of true involvement and engagement. Care plans were often basic, subject to cut and paste (from previous entries) and not in keeping with the Service Users' presentation and needs. Whilst involved Service Users often did not agree with the resultant process.
▪ Carers are involved throughout assessment and planning stages whenever possible.	✓	This standard was unmet in 1 case, partially met in 2 cases and met in full in 2 cases. Carers sometimes found it difficult to contribute to ongoing assessment processes if the Service Users did not want them involved; this led to important information about crisis and relapse being missed and/or picked up upon in a tardy manner.
▪ (CPA Policy) all service users will be treated with respect and will be enabled to make informed choices.	✓	This standard was met in full for 3 cases, was not met in 1 case, and was partially met in 1 case. In the 3 cases where the standard was met full consultation with the Service User was evident and choices discussed. In the unmet case (the Service User was a child for the majority of the time) the language used was often disrespectful and patronising – e.g. described '*alleged*

		sexual abuse' throughout the record when the abuse was not alleged but fact and had resulted in prosecution of the perpetrators. Choices were minimal and a strict and overly boundaried approach was taken. In the partially met case the approach taken was dependent on the professionals involved. This ranged from exemplar inputs at one end of the scale - to unhelpful inputs on the other end of the scale. The disrespectful inputs served to alienate the Service User.
Care Coordination		
▪ The care coordinator oversees the implementation of the assessment and care planning process.	✓	This standard was substantially met – however in 1 of the cases the Service User had 3 different care coordinators at the same time from 3 different agencies – it was not always clear who led assessment and planning in the early years for this individual.
▪ The responsibilities of the care coordinator as set out in Trust policies (past and present) are adhered to.	✓	This standard was substantially met. However care plans were often 'cut and paste' and not kept up-to-date. Care coordinators often appeared to be working as community-based professionals rather than coordinators of care between other agencies and/or other Trust services.
▪ When care coordinators change a thorough handover takes place.	✓	This standard was substantially met – however it was difficult to assess this standard in full due to the concise nature of the clinical record.
▪ Professionals and Services involved who are unable to attend the formal review make any relevant information available to the care coordinator prior to the formal meeting so that this can be discussed at the review.	✓	This standard was met in full in 1 case, partially met in 1case, not met in 2 cases, and NAD for 1case.
▪ Reviews are organised at a time and location which best meets the needs of the Service User.	✓	This standard was substantially met.
Multi-disciplinary Input		
▪ A consultant psychiatrist is directly involved in clinical decision making.	✓	This standard was substantially met – however at times it was unclear how consultant psychiatrists directly inputted into risk

		assessment and care planning.
▪ All staff involved in the care of the Service User are consulted throughout the assessment and planning process.	✓	This standard was partially met but was difficult to assess due to the concise nature of the clinical record. The approach was inconsistent in relation to multi-agency working in 2 cases.

Issues for Further Consideration

1. It is unclear how any concerns about parenting and child safeguarding are transferred into risk assessment processes.
2. It is not clear how risk guidance from the CPA policy is detailed on formal risk assessment documentation as opposed to CPA documentation.
3. There needs to be a great deal of policy cross-referencing in order for practitioners to understand in full all risk assessment, safeguarding and risk planning requirements. This fragments the guidance and might not be helpful when ensuring all due consideration to risk is both made and recorded.

Summary: The focus of the treating teams appears to have been on managing crisis or acute presentations. Once ‘recovered’ Service Users were usually discharged from CPA (and usually from all community-based services). The focus was not on ongoing recovery and wellbeing – the 5 Service Users had all become unwell at a relatively early stage in their lives – this meant that as troubled adults they had few coping skills and often had significant needs – CPA/community services did not seem to recognise or meet these needs; this probably made a contribution to the repeat cycle of relapse that occurred.

Care coordinators appear to work as community-based professionals rather than coordinators of care. Care coordinators did not seem to take an active role in multi-agency liaison, assessment and planning; neither did care coordinators act as key links between Trust-based services if the Service User was open to more than one service at a time.

The clinical records are overly concise across all 5 cases – it is evident that there is a consistent tendency to ‘cut and paste’ from previous care plans regardless of whether the information was up-to-date and represented current presentation and need.

4. Managing Disengagement

▪ Service Users referred for care coordination are not left without follow up (due to the disengagement of the service user).	✓	This standard was partially met. It was met in full for 3 cases, was NAD for 1 case and was partially met for 1 case. Often the approach taken was not assertive enough given known risks and presentation.
▪ Service Users not on CPA are followed up and a risk assessment considered and a plan of care developed.	✓	This standard was not met for 2 cases, was NAD for 1 case and was partially met for 2 cases. The main weakness was an absence of risk assessment and care planning.

▪ When a Service User does not engage every effort is made to find out why and the reasons recorded.	✓	This standard was partially met – CMHT workers would usually conduct routine follow up. However follow up was often inconsistent much of the time with the reasons for disengagement not always being understood or explored. In some instances long periods of time would go by leading to total relapse before any action was taken. Little attention was paid to known relapse signatures where disengagement was already noted to be an issue.
▪ CMHTs include an outreach service that provides support to Service Users who are difficult to engage.	X	This standard was substantially unmet. It was not met in 3 cases, was NAD for 1 case, and was partially met for 1 case. In the partially met case there appears to have been some kind of assertive outreach approach – in the other 3 cases engagement was left to the care coordinators to manage.
▪ Service Users who meet the criteria for CPA are not discharged solely on the grounds they are uncooperative.	✓	This standard was partially met – in 2 cases it was NAD, in 2 cases Services Users were discharged for lack of attendance/cooperation, and in 1 case a good level of follow up was evidenced when the Service User disengaged/did not comply.
▪ All possible efforts are made by the care coordinator to stay in touch with the Service User and work at developing a relationship that will enable increased engagement.	✓	This standard was partially met. It was met in full in 1 case, was NAD for 1 case and was partially met in 3 cases. It was evident that the levels and quality of input varied over time for 3 of the Service Users depending on the care coordinator who managed the case at the time. Inputs were frequently of a very high standard – at other times inputs tailed off even when significant concerns were being recorded and engagement receded.
▪ The decision to discharge from services is agreed by the care team at a CPA Review. Service Users who meet the criteria for CPA are not discharged solely for disengaging or failing to keep a fixed number of appointments – consideration is always given to the degree of mental	✓	This standard was partially met. 1 case was NAD, 2 cases were not discharged for disengagement, and 2 cases were discharged for disengagement and a failure to attend appointments – even when significant risks were noted on file.

illness and the level of risk posed.		
▪ As part of the assessment and review process a proactive discussion takes place with the Service User/carer to agree the actions and risk management plan in the event of their early or longer term disengagement and a care plan agreed.	X	This standard was not met. There is no mention in the contact notes or care plans regarding the management of disengagement – even when it has been identified as a relapse signature.
▪ If there is a serious risk of suicide, self-neglect or harm to others through the service user's refusal to engage then compulsory admission and treatment under the Mental Health Act (1983) is considered.	✓	This standard was partially met. It was NAD for 1 case, met in 3 cases, and was not met in one case.
▪ An agreed care plan is developed for Service Users who do not engage with care and treatment (this to be multi-agency if indicated).	X	This standard was not met. It is evident that Service Users would regularly disengage and then become increasingly unwell in a repeat cycle. There were no plans to address these patterns and no curiosity shown as to why Service Users disengaged.
▪ For Service Users with a history of a loss of contact, trigger factors are identified and action is documented within the risk management strategies recorded on the care plan in relation to relapse.	X	This standard was not met (see directly above).
▪ If a Service User misses an appointment and contact cannot be established then third parties such as relatives, carers, GP, support services, the police are liaised with.	✓	This standard was partially met. It was NAD for 1 case, unmet in 3 cases, and met in full in 1 case.
▪ Where there are dependent children within the household of a Service User with mental health needs, special consideration is given to the implications this may have for those children.	X	This standard was substantially unmet. It was NAD for 4 cases and unmet in 1 case where a young child was involved and the Service User a known risk regarding substance misuse and violence.

Issues for Further Consideration

1. The engagement policy is an example of good practice – but is it achievable? How feasible it is to liaise with the GP and Social Services

(for example) every time a Service User disengages? How responsive will these other services be? What exactly is the Trust trying to achieve by doing this? What does the Trust actually expect of these other services? The policy might be a bit over optimistic and it is evident many of the actions advised are not put into practice.

2. Is the assertive outreach team resourced fully across the Trust? The Promoting Engagement and Access to Mental Health Services Standard Operating Procedure (March 2021 – March 2022) suggests the use of Assertive Outreach – but in reality this is not a uniform provision across the whole Trust – the expectation is unrealistic.
3. What are the CMHT outreach services? How are they resourced? How can they be improved within the existing resource?
4. How does audit support the engagement policy in practical terms? What is actually audited?

Summary: It is evident that some care coordinators worked very hard following up non-attendance and disengagement. However it is also evident that the reasons for Service User disengagement were not explored in an open manner and that the Service Users in this review often disengaged from service for extended periods of time.

The Trust has explained that there is a limited assertive outreach service in the traditional sense and that CMHTs ‘provide’ this within the existing provision.
Disengagement and non-compliance with care and treatment was a regular feature across all 5 cases. However there are no recorded discussions or care plans on file as to how this was managed. The Service Users appear to have had a repeat pattern of disengagement/non-compliance and relapse. This pattern (which is often a predictable feature for those with severe and enduring mental illness) was not managed proactively – instead a reactive stance was taken when a crisis situation was reached and intervention required.
It is of note that for 2 Service Users discharge was implemented for disengagement/non-attendance at appointments despite ongoing risk and significant mental health issues.

5.Carer Engagement and Involvement		
Carer Assessment - All Service Users are asked at assessment and reviews to identify carers who provide regular and substantive care. Where such carers are identified they are offered a carer assessment and an annual reassessment of their needs (under the requirements of the Care Act 2014).	✓	This standard was partially met. It was met in 1 case, NAD for 2 cases, was partially met in 1 case and was not met in 1 case. In the partially met case offers for carer assessments were made – however the relationship had broken down between the carer and service in general and the offers were often declined. In the unmet case – an offer was made – but there is only a single blank carer assessment on file.
Carer Engagement and Involvement - There is evidence to demonstrate that carers are involved, listened to with respect and that any concerns	✓	This standard was partially met. This standard was met in 2 cases, was unmet in 1 case, and was partially met in 2 cases.

raised by them are considered respectfully and examined appropriately.		Where the standard was not met/partially met it would appear that whilst carers were involved in CPA, day-to-day concerns about worsening presentation were not always addressed in a timely manner – and some carers (on occasions) had their concerns dismissed and/or downplayed.
▪ Carers are kept informed if any issues affecting their personal safety are identified.	✓	This standard was substantially met.
▪ Carers are consulted when Services Users disengage from service.	✓	This standard was partially met. It was met in full in 2 cases, was partially met in 1 case, and was unmet in 2 cases. It is of note that for the partially met case the Service User was a child for most of his time with the Trust and his lack of engagement/non-compliance should have been managed more robustly with his carers.
Issues for Further Consideration **1.** How is the uptake of carer assessment monitored? **2.** How do Trust services liaise with Social Services/General Practice to support carers with vulnerabilities/special needs? **Summary:** the main issue is not so much how services communicated with families and carers in formal settings (such as CPA reviews) – but how they responded to the day-to-day concerns raised by carers when Service Users were relapsing. Carer concerns were not always addressed in a timely manner – and neither were they always addressed with the carers' ongoing wellbeing, safety and support in mind.		
6. Access to Service, Resource, Referral and Waiting Times		
▪ Duty Workers ensure all relevant information about referrals is recorded and liaison with referrers/transferors to service takes place.	✓	This standard was partially met. In 1 case there was not enough documentation to assess the standard, 1 case was not met, 2 cases were partially met and 1 case was met. In general referral information was of a variable quality – liaison communication was brief and referral documentation was often incomplete with many fields on the forms left blank.
▪ All Service Users who can no longer be managed in a primary care context are accepted and managed by CMHT services (including Service Users with severe	✓	This standard was partially met. It was partially met in 2 cases, met in full in 2 cases, and was not strictly relevant in 1 case. In the partially met cases it was sometimes unclear which service

personality disorders).		should intervene and provide care, on 2 occasions a Service User was referred by the GP but discharged due to non-attendance before being seen.
▪ When referrals are not accepted the reasons for this are sent to the referrer in writing within 72 hours of the decision being made.	-	This standard was largely NAD for the cases under review – however in one case there were some examples where refusals to accept referrals were not recorded and were not made clear.
▪ Following referral Service Users are contacted by telephone to arrange an initial appointment – if this is unsuccessful the Service User is contacted in writing urging them to contact the service. After 2 weeks if no contact is made then a further letter is sent. The case is discussed with the MDT and if there are no concerns the Service User is discharged back to the care of the GP.	✓	This standard was partially met. It was met in 1 case, there was insufficient documentation to assess 2 cases, was NAD for 1 case, and was partially met in 1 case. In the partially met case referrals were managed well historically – however the last 2 referrals were not managed well as the instructions advised by the GP re-contact were ignored and the patient did not engage as a consequence.
▪ When a Service User DNAs the first appointment 2 attempts to contact the Service User are made. A new appointment is made and details sent to the service user giving a 2-week notice period. If the Service User DNAs the second appointment they are removed from the waiting list.	✓	This standard was largely NAD for 3 of the cases. In 1 case there was insufficient documentation to assess the standard. In 1 case the standard was partially met (see the comments already provided for the standard directly above).
▪ Following DNA the decision to remove from a waiting list is made following a recorded risk assessment and the GP written to.	✓	This standard was largely NAD for 3 of the cases. In 1 case there was insufficient documentation to assess the standard. In 1 case the standard was partially met - a risk assessment was conducted – but it was a cut and paste from a document written over a year before and did not address any of the current/pertinent issues relating the to the 2018 referral. The Review Team could not find a copy in the GP record.
7. Multi-Agency Working		
▪ Records pertaining to Service Users and pertinent to their ongoing care, treatment, wellbeing and safety can be	X	This standard was not met. Several of the Service Users were open to other agencies during their time with the Trust – 3 posed

accessed by all agencies as required.		significant risks to others or were at risk from others – documentation and information from other agencies appears to have been minimal.
▪ Care planning, risk assessment and documentation processes are developed/shared in an inter-agency manner following consultation and ongoing team working in the best interests of service users and the safety of the general public.	✓	This standard was partially met. However there are few examples of joint working – it appears that different agencies worked in parallel rather than jointly – even when MAPPA was in play. 2 of the Service Users had a degree of multi-agency working ongoing – but there was often duplication and parallel activity – there was no effective shared assessment and planning process. Meetings occurred – by they appear to have fallen short of a joint working ethos.
Issues for Further Consideration **1.** Multi-agency working appears to be run in parallel the majority of the time – it is unclear how policies and protocols for joint working are both developed and implemented. **Summary:** the lack of multi-agency partnership working was a key feature of the cases under review – with particular reference to Social Services and Probation. Despite intense levels of input from several different agencies at the same time – there was little joint working (e.g. risk assessments, information sharing, care planning) that put the Service User at the centre of the activity. It was also evident that shared access to information was problematic and that assessment, monitoring and planning took place in parallel.		
8. Adherence to Policy and Procedure (local and national best practice)		
▪ Trust policies and procedures are adhered to. ▪ The Trust has clear and demonstrable assurance processes to ensure policy adherence. ▪ All staff access mandatory training appropriate to their roles.	X ? ?	Examination of the 5 cases in the Review demonstrates that fundamental aspects of Trust policy and procedure are not adhered to on a routine basis. The standards that comprise this review proforma have been taken (in large part) from Trust policy and procedure and there are key areas which signal non-adherence over a number of years across all 5 cases. It is probable that mainstream audit and assurance processes are not always sensitive enough to detect non-adherence.

Themes Identified from the Independent Review Process		
9. Safeguarding		
Children ▪ Staff in adult mental health services caring for a parent always considers the child’s needs and the potential for physical and psychological harm as primary task of the CPA and as part of multi-agency risk assessment processes.	X	This particular standard was NAD for 3 of the Service Users in the review. However of the 2 remaining cases, the first Service User was actually a child himself and had an adult safeguarding form completed (as though he was the parent and not the child) which was confusing, the second Service User had 3 children – one of whom he lived with. However there was only ever one mention of the child being potentially at risk – it was evident the child’s needs and risks were not the primary focus of CPA despite his father’s substance misuse and past history of extreme physical violence. There was no assessment and no plan.
▪ Risk assessments of mental health Service Users are not based solely on the information they can provide. If the Service User has, or resumes contact with children, this triggers an assessment of whether there are any actual or potential risks to the children, including delusional beliefs involving them, and drawing on as many sources of information as possible, including compliance with treatment.	X	This standard was NAD for 2 of the cases. It was unmet in the other 3 cases. All 3 Service Users were in regular contact with children (one was also a child himself for the majority of time he received Trust services) – no assessments were made specifically in relation to the risks to children: non-compliance with treatment, substance misuse and anger management were all identified as ongoing issues.
▪ Assessments, CPA monitoring, reviews, and discharge planning arrangements and procedures prompt staff to consider if the Service User is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the Service User, and consideration is given to any risks posed to those children.	X	This standard was not met – of particular concern was when Service Users were discharged due to not attendance at appointments. Risks posed were not recorded within the clinical record.

▪ All staff ensure safeguarding and promoting the welfare of children and young people forms an integral part of all stages of care and assessment.	X	This standard was not met for the reasons set out above.
▪ Information about the child/children in families is recorded at assessment or as soon as possible and recorded on CPA documentation/client records. When any pre or postnatal Service User is receiving care the health visitor/midwife must be routinely informed of mental health services involvement, to aid sharing of information.	✓	This standard was partially met. However the clinical records are overly concise across the 3 relevant cases and it is difficult to understand how child safeguarding was managed. Considering the background and history of the 3 Service Users (one still a child who had been the victim of proven sexual abuse – the other 2 known to perpetrate violent assaults) more detail was merited at the outset of contact with mental health services.
▪ Staff implementing the CPA process are mindful of Service Users/carers responsibility for children and consider the welfare of children at every stage of the CPA process utilizing the Framework for Assessment of Children in Need and their Families (see LCFT Safeguarding and Protecting Children Procedures SG001).	X	This standard was not met – this consideration was absent from the clinical record.
▪ When a Service User poses any threat to children then a CPA review is called at the earliest opportunity and a consultant psychiatrist is directly involved in all clinical decision making.	X	This standard was substantially unmet and is of relevance to 2 of the Service Users under review. On 2 occasions incidents were reported (one for each Service User) but the documentation is sparse and underdeveloped and it is not clear how the situations were managed or how Social Services worked with the Trust. CPA reviews were not used specifically to address the needs of children.
▪ A referral to children's Social Services is made under Local Safeguarding Children Board procedures as soon as concerns are identified for a child/children's welfare, there is a problem, suspicion or concern about a child, or if the child's own needs are not being met.	✓	This standard was partially met. Referrals were sometimes made in relation to child safeguarding – however the clinical record is sparse and overly concise. It is not possible track what the outcomes were – there is little by way of follow up or review – there were no subsequent changes to care plans or ongoing recorded liaison with Social Services beyond the most basic.

▪ The care coordinator and all staff providing care are made aware of any disclosures made and Police Public Protection Unit notified as well as children's social care, in line with LSCB procedures. Staff identify if Multi-agency Public Protection Arrangements (MAPPA) have been put into place. ▪ Service Users with substance misuse problems who live with children/vulnerable adults are notified to Social Services.	X X	This standard was substantially unmet. 3 of the Service Users had either MAPPA or YOT involvement together with histories of significant violent assault. There appears to have been little join-up in relation to the safety and wellbeing of children recorded in the clinical record. This standard was substantially unmet. All 3 of the Service Users relevant to this standard had regular substance misuse habits - all 3 spent a great deal of time with children. It would appear that Social Service notifications were not made in relation to this.
Vulnerable Adults ▪ Risk assessments of mental health Service Users are not based solely on the information they provide. If the Service User has or may resume contact with a vulnerable adult or is at risk him/herself this triggers an assessment of whether there is actual or potential risk; drawing on as many sources of information as possible to assess that risk and including delusional beliefs involving them or another vulnerable adult. ▪ Assessments, CPA monitoring, reviews, and discharge planning arrangements and procedures always include consideration of potential vulnerability of the Service User and/or other potentially vulnerable adults or children the	X X	This standard was substantially unmet. It was unmet in 2 cases, was partially met in 1, there was insufficient documentation to assess 1 case, and was NAD for 1 case. All 5 of the Service Users were described as being vulnerable on occasions (self neglect, weight loss due to poor day-to-day functioning, risk of exploitation etc.). 1 of the Service Users was routinely described as being a vulnerable adult, but there was no capacity assessment or care plan to address this. Another Service User had been made homeless due to having dug up the floor of his home and destroyed most the fabric of the building (due to his ongoing mental state) – whilst a referral to Social Services was discussed he was not assessed or regarded as a vulnerable adult – there was good practice in that information was drawn from many sources – but it was difficult to understand what the planned interventions were to protect this individual. This standard was not met. Vulnerability was addressed in a 'tick box' manner during assessments and reviews. The word 'vulnerable' would often appear across all 5 cases – but no further consideration was taken. The vulnerability and safety of

Service User may have contact with and consider any risks posed.		children were not routinely assessed or considered.
- When a Service User poses a risk to a vulnerable adult or is at risk of abuse as a vulnerable adult a CPA review is called at the earliest opportunity and the LCFT Safeguarding Adult Procedures SG008 are followed.	X	This standard was not met.

Issues for Further Consideration

1. The words ‘vulnerable’ and ‘vulnerable adult’ are used frequently in the clinical record – however it is not clear what is meant. It is never clarified whether or not a capacity assessment has been conducted and whether the words ‘Vulnerable Adult’ are used in keeping with the Mental Capacity Act.
2. The requirements of the safeguarding and CPA policies are not specifically outlined in the Trust risk assessment policy and assessment documentation – this appears to foster a somewhat cursory assessment in relation to safeguarding. The Basic risk assessment and safeguarding assessment tools are ‘tick box’ in format and do not appear to support a full narrative analysis.

Summary Safeguarding Children: the ongoing health, safety and wellbeing of children were mentioned in a ‘tick box’ manner (if mentioned at all). There was a non-adherence to Trust policy guidance across all of the relevant cases and the spirit and ethos of safeguarding children was not seemingly understood.

Summary Vulnerable Adults: vulnerability is mentioned frequently within the clinical record – however it was rarely examined in full and it was rare for a Social Services referral to be made. Mentioning vulnerability in the clinical record did not lead to ongoing plans for support and monitoring. The 5 Service Users under review all appear to have been affected by mental illness at a relatively early stage in their lives and this may affected their ability to learn to undertake all of the usual activities of daily living (financial management, environmental management of the home, diet etc.) – the Recovery Model did not appear to address these issues (the possible underlying cause for ‘vulnerability’ and self neglect as cited in the clinical records) – the focus instead being on medication, crisis management and day-to-day monitoring.

10. Escalation Pathways and Access to Mental Health Services

- Services are accessible so that appropriate treatment can be obtained when and where it is needed.	✓	This standard was partially met. It was met in 2 cases, partially met in 2 cases and was unmet in 1 case. All 5 cases had high levels of activity – but it would appear that this activity was not always provided by the ‘best fit’ service. 1 Service User was often closed to service (even as a child due to his behaviour) but it was not evident what the alternatives were – or even if there were any. The CCTT (complex care and treatment team – part of

		the CMHT) appears to have been the main service provider – it was not clear how Recovery and Assertive Outreach was provided within the CCTT provision – or how specialist PD services were accessed.
▪ Where risks are complex and hard to formulate the case is taken to a Complex Case Forum so that the most senior clinicians in the team are involved in the care and clinical management.	X	This standard was not met. It was unmet in 2 cases and was NAD for 3 cases. In the 2 unmet cases it was evident that the Service Users were complex, involved with multiple agencies and not improving over time. A Complex Care Forum was indicated. There are no records to suggest this approach was considered.
▪ Relapse signatures are identified, and when apparent, urgent communication takes place to manage care.	✓	This standard was partially met. It was unmet in 2 cases and partially met in 3 cases. Relapse signatures were infrequently recorded – however even when recorded they were not usually seen as prompts for intervention (particularly in relation to disengagement and non-compliance with medication). Intervention usually occurred when the Service User either reached a point of crisis or when they self-reported deterioration in their mental health.
11. Record Keeping and Professional Communication		
▪ Clinical data is captured in an accurate and timely manner.	✓	This standard was partially met in 4 cases and met in 1. Records were made in a timely manner – however they were often overly concise and a 'cut and paste' approach was taken to risk assessment and care plans – this meant records were often inaccurate and out-of-date – not matching the content of the Contact Notes. Many forms were often blank or only partially completed. Record keeping appears to have been better prior to 2015 in some cases (we do not understand why).
▪ All procedures (diagnostic assessments, histories, and other kinds of assessments) are documented and updated.	✓	This standard was partially met in 3 cases, met in I and unmet in 1. The standard was variable over time and was also variable in relation to individual recording practice. Some records were of a good standard – but in general there were significant gaps in the

		record (risk assessments, care plans, histories etc.), regular ‘cutting and pasting’ of out-of date information, and the incomplete filling in of forms. The overly concise style meant it was difficult to understand and track clinical decisions and planning.
▪ The NHS Number and another identifier (e.g. patient name or date of birth) are used at all times with patient identifiable data.	✓	This standard was partially met in 3 cases and met in whole in 2 cases. NB: some documents sent to the Independent Review Team had no patient identification – however this might have been due to the collation process when gathering the records together – and might not represent usual day-to-day practice.
▪ Staff and patients are not put at risk through invalid or incorrect decisions being made about a patient’s care (due to poor record keeping practice).	✓	This standard was partially met. 1 Service User appears to have been placed at risk by out-of date information being accessed when in Police custody. With 2 other cases out-of-date risk assessments might have contributed to less than optimal approaches being taken over time.
▪ All Trust treating teams have access to a Service User’s complete clinical record when making specialist assessments (e.g. when services users are in Police cells awaiting forensic assessment).	✓	This standard was partially met in 1 case, unmet in 2 cases, met in 1 case and NAD for 1 case. The significant gaps in the clinical records suggest that disparate treating teams/agencies do not have automatic access to a Service User’s complete record. In the case of 1 Service User it was apparent that whilst in Police Custody the forensic teams assessing him accessed an incomplete record which appears to have been significantly out-of-date. This had an impact on how he was managed by the Criminal Justice System.

Issues for Further Consideration

1. The clinical records are overly concise across all 5 cases and over a period of some ten years; however inpatient records tend to be more detailed. There was a lack of medical notes (histories, MSEs, diagnostic impressions and formulations) – the Independent Review Team cannot be certain whether or not the records sent to D&J were incomplete – or whether medical clinicians do not routinely make detailed clinical entries in the patient record. The Trust needs to understand whether RiO is responsible for the relative lack of accessibility of certain clinical records – or whether medical clinicians need to reflect on their clinical record keeping practice.
2. There were significant gaps in the clinical records sent to the Independent Review Team – it is impossible to understand whether the

complete records were sent (and record keeping is of an exceptionally poor quality) or whether the 'incomplete records' are as a result of Trust access/retrieval issues. Either way – the Trust needs to understand this in order to ensure improved record keeping/access/retrieval for improved patient care. 3. It is evident from the clinical records sent to the Independent Review Team that there are significant gaps in the records (an almost complete absence of risk assessments and care plans in some cases). It is apparent that the Trust's audit systems are not sensitive enough to detect these omissions. 4. There is a significant degree of 'cut and paste' – this practice allowed for out-of-date information to be repeated over the years in risk assessments and care plans – it is evident that the content in these documents are not usually in keeping with the information provided in the day-to-day contact notes. It is apparent that the Trust's audit systems are not sensitive enough to detect this practice. 5. It is uncertain how professional communication between services and agencies is achieved from an examination of the clinical record – there are significant gaps in the record with services (and agencies) often appearing to run in parallel rather than in partnership.		
12. Multidisciplinary (MDT) Team Working		
▪ Assessments are conducted following full MDT contribution and discussion.	✓	This standard was partially met in 4 cases and there was insufficient evidence to assess 1 case. MDT meetings did take place – but it was not always possible to 'marry up' the recorded MDT discussions and the care plans and risk assessments that were also placed on file. Care plans and risk assessments appear to be uni-professional in nature with a high degree of cut and paste from previous documents. Inpatient settings were the exception where there was a clear MDT meeting/discussion connection with subsequent care planning and risk assessment.
▪ Clinical decisions are based upon the views and clinical expertise of the entire MDT.	✓	This standard was partially met in 3 cases and there was not enough evidence to assess 2 cases. It was possible to trace connections on occasions – especially in inpatients settings – however in community contexts it was not always possible to connect the recorded multidisciplinary meetings with the care plans and risk assessments that were developed.
▪ Disagreements between MDT team members are managed in an objective and supportive manner by the team manager.	X	This was NAD in 4 cases and not met in 1 case. In the single case it appears that the team manager was neither notified nor involved.

13. Care Pathways and Evidence-Based Practice		
▪ Clinical decision making is guided by national best practice evidence-based guidance.	✓	This standard was partially met in 2 cases, unmet in 1 case, and there was insufficient evidence to assess 2 cases. Care pathways did not appear to match diagnosis and/or national NICE guidance.
▪ Trust services and operational provision are constructed in a manner to facilitate NICE guidance and other national research-based evidence guidance.	✓	This standard was partially met in 2 cases, unmet in 1 case, and there was insufficient evidence to assess 2 cases. There was an apparent lack of synergy between services and there were also seeming gaps in service provision. Care Pathways were often not in keeping with diagnosis and NICE guidance – the services delivered all appeared to be based upon medication and community-based visits – there was a lack of therapy and recovery-based services.
14. Care Clustering and Assessment		
▪ The care clustering tool is not used in lieu of a clinical assessment – but is instead based upon a MDT holistic clinical assessment.	X	This standard was substantially unmet. The clustering tool appears to have been used as a stand-alone assessment – there was little evidence to suggest that other kinds of assessment fed in to the care clustering process.
▪ Transitions between services are considered following the use of the care clustering tool only when clear milestones and clustering criteria have been met.	X	This standard was not met. Assessment appears to have made no difference to the care pathway followed, care planning, or approach taken. Ratings were not consistent and the forms were sometimes completed by non-NHS staff. Transitions and discharges appear to have been managed without any reference to the care clustering process. It remains unclear exactly what function the care clustering tool has within the Trust.
▪ Changes to care clusters are considered after a Service User experiences a period of recovery and stability.	X	This standard was substantially unmet. Periods of stability were not a seeming driver to accessing services. Changes charted on the care clustering tool had little impact on the care pathway followed and the rating scales often ran counter to the narrative within the Contact Notes.

15. Service User Involvement		
▪ Service Users as involved fully in their care and treatment.	✓	This standard was partially met in 2 cases and met in full in 3 cases. The 2 unmet cases both had PD as part of their diagnostic profile – it was evident neither Service User was entirely happy with the care and treatment package offered but they were not listened to and experienced a degree of coercion which served to distance them from the treating team.
▪ Service Users are treated with dignity and respect at all times.	✓	The language used was often disrespectful and differences of opinion between the Service Users and their treating teams were often managed in a 'high handed manner'.
▪ Requests for second opinions/complaints about service are taken seriously and actioned with immediate effect. ▪	✓	This standard was partially met for 1 case and NAD for 4 cases.
▪ Advanced statements are discussed with Service Users and recorded appropriately.	X	There were no advance statements to be found in the clinical records of all 5 cases. Relapse and acute psychotic presentation were not discussed with Services Users when well and did not inform crisis and contingency planning.
16. MAPPA, Transition from Prison and Police/Probation Involvement		
▪ The Offender Pathway is followed.	✓	2 of the Service Users had been in prison directly prior to joining Trust services – there is mention in the clinical records of some kind of Offender Pathway being followed. However due to the concise nature of the clinical records it has been difficult to evidence. NB: It is evident with Cases 2 & 5 that Offender Services (the Police Revolution Team, Probation etc.) were involved – however inputs from other agencies did not always 'sit' within the expectations of the Trust's formal offender pathway.
▪ If a Service User is on MAPPA then this is an agenda item at every CPA review.	X	This standard was not met even when Service Users were subject to MAPPA.

▪ Comprehensive risk assessments are developed which take advantage of coordinated information sharing across agencies.	✓	This applies to 3 of the Service Users in the Review. Whilst risk assessments were sometimes shared initially this did not continue as a regular practice – there was virtually no sustained information sharing across the disparate agencies according to the content of the Trust-held clinical record.
▪ Care coordinators from community teams attend MAPPA meetings.	X	This standard was not met – Trust-based care coordinators did not attend MAPPA meetings.
▪ The MAPPA policy and procedures are adhered to.	X	The Trust-held clinical record suggests not.

Reference Documents

NB: the internal Trust policies listed below are those made available to the Independent Investigation Team. The policies are either recent or current and provide a guide to the standards in operation at the time care and treatment was delivered.

1. Procedure for the Assessment and Management of Clinical Risk in Mental Health Services (May 2015 – May 2018)
2. Assessment and Management of Clinical Risk in Mental Health Services Policy and Procedure (March 2021 – March 2024)
3. *Best Practice in Managing Risk published* Department of Health (2007)
4. *National Confidential Inquiry into Suicide and Safety in Mental Health* (2019) Annual Report 2019; England, Northern Ireland, Scotland and Wales. The University of Manchester
5. Care Programme Approach Policy (and CPA Procedures) (August 2015 – September 2018)
6. Care Programme Approach Policy (and CPA Procedures) (April 2019 – April 2022)
7. Community Mental Health Team Standard Operating Procedure (2021)
8. Data Quality Policy (2018 – 2021)
9. Waiting Times and Patient Access to Services Policy (2018 – June 2021)
10. Medicines Management Policy (2020 – 2023)
11. Data Quality Policy IMT 018 (May 2018 – March 2021)
12. Protocol for the Transition of Service Users between Lancashire Care NHS Foundation Trust Prisons & Mental Health Services (2017)

13. Multi-Agency Public Protection Arrangements (MAPPA) Procedure (2021 – 2023)
14. Promoting Engagement and Access to Mental Health Services Standard Operating Procedure (March 2021 – March 2022)
15. *The Mental Health Clustering Tool: How to allocate to Care Clusters in IAPT services* Royal College of Psychiatry (2021)
16. *Mental Health Clustering Booklet* NHS England (2015/2016)
17. *Core Values for Psychiatrists* College Report CR204 – Royal College of Psychiatrists (2017)
18. *Good Psychiatric Practice* Royal College of Psychiatrists (2009)