April 2019

Independent Review of the Level 2 Trust RCA investigation into the care and treatment of Mr D by Kent and Medway Partnership NHS Foundation Trust

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1 EXECUTIVE SUMMARY

Introduction
Mr D was 62 years old and lived alone at the time of the serious incident in May 2017. Mr D had used mental health services over a 20 year period. His most recent referral was to Kent and Medway NHS and Social Care Partnership Trust secondary mental health services in May 2015. He was referred by his GP to Canterbury Community Mental Health Service for Older People (CMHSOP) for a review and opinion about memory difficulties he was experiencing. Mr D remained under the CMHSOP until February 2017 when he was discharged from the service to the Canterbury and Coastal Community Mental Health Team (CMHT). The CMHT did not accept Mr D's referral and he was discharged from the service the same month. Mr D and his GP were not informed of this decision. The Trust had no further contact with Mr D.

Mr D assaulted his neighbour, Mr J, with a hammer on 18 May 2017. He contacted the police the next day to report what he had done and to raise concerns about his neighbour. The Police attended Mr J's address where he was found deceased. Mr D was arrested and charged with Mr J's murder the same day. He was convicted of murder in November 2017 and sentenced to a minimum of 12 years in prison.

NHS England (NHSE), South, commissioned Mazars to undertake an independent review of the Trust RCA investigation into the care and treatment of Mr D and its progress against the internal investigation action plan. The review extended to considering the Clinical Commissioning Group's (CCG) assurance processes in relation to the Trust's investigation and progress with its action plan.

Chronology
Mr D had an extensive history of engaging with mental health services over 20 years. He was also in frequent contact with primary care services over this period. However, despite this contact, there were sustained periods during which Mr D would disengage with services. Mr D was also known to abuse alcohol/substances, had troubled relationships with his family and in the latter years of his contact with Trust service, was grieving the loss of his son.

Mr D was referred by his GP to the CMHSOP in 2015 for a review of memory difficulties he was experiencing. Mr D was assessed by staff who concluded the possible reasons for his memory difficulties included stress, grief, depression, medication and his drug and alcohol use. He had an MRI head scan to check whether there was any alcohol related damage or neurodegenerative change. The MRI did not identify significant findings and Mr D remained under the care of the CMHSOP.

Mr D was seen by the CMHSOP Consultant Psychiatrist in January 2016, who concluded that Mr D's memory difficulties were not neurodegenerative in origin, and that social factors, alcohol misuse and Mr D's history of head injuries, could all be attributable. Mr D was referred for neuropsychological assessment. A Clinical Psychologist for older people subsequently made attempts to arrange an appointment for Mr D to be assessed, but he did not attend and she referred him back to the community team. Mr D engaged intermittently with the CMHSOP throughout 2016 – he would sometimes initiate contact, but then wouldn't always respond to the service's attempts to contact him.

The CMHSOP undertook a home visit on 30 January 2017 in response to concerns raised by a friend of Mr D. Mr D was noted to be alert and well attired. Mr D said that he had not been taking his antidepressant because he was unsure it worked and wished to stop taking it. It was agreed that Mr D would be referred for a psychological assessment and reviewed

by the CMHSOP in four months. A copy of Mr D's care plan – written by Speciality Doctor 2 - was sent to Mr D's GP who was asked to stop his Sertraline prescription.

A CMHSOP multi-disciplinary team (MDT) meeting attended by Speciality Doctor 2 and Consultant Psychiatrist 7 took place on 1 February 2017. The team felt that the complexity of Mr D's needs would be best met by the CMHT. It was recorded in the notes that Mr D's primary difficult was *"anxiety in the context of traumatic/distressing past events, alcohol abuse and poor social functioning. His cognitive impairment appears to be secondary to his anxiety rather than organic in nature. Not appropriate for psychological therapy within the Older People services as no issues typical for older age"*. It was agreed Mr D should be referred to the CMHT and discharged from the CMHSOP.

Mr D was referred to the CMHT and discharged from the CMHSOP on 1 February 2017. The CMHT did not accept Mr D's referral, concluding that Mr D did not have a degenerative disorder, but complex mental health issues with a background of alcohol dependence syndrome which would benefit from therapy. The team contacted the CMHSOP to inform it of its decision but there was no formal record of the contact and the CMHSOP was unaware that the CMHT had rejected the referral. Mr D and his GP were not informed of this decision.

The Police contacted Medway and Swale Crisis Resolution Home Treatment team (CRHTT) on 26 February to ask if Mr D was known to Trust services. The CRHTT (unknowingly incorrectly) advised that Mr D was under the CMHSOP. The Citizen's Advice Bureau telephoned the CMHSOP Outpatients Psychology service on 10 April 2017 on behalf of Mr D. They explained that there had been some confusion on Mr D's part in relation to arranging a psychological assessment but that he would like to book an appointment. The member of staff who took the call advised that she could not discuss Mr D's case but that she would arrange for a letter to be sent to him. A letter was subsequently sent to Mr D telling him he had been discharged from the CMHSOP on 1 February 2017 and that he should contact his GP for assistance.

Mr D attended his GP surgery in April and May 2017. No concerns were documented in the notes in relation to his mental health. Mr D attended an orthopaedic clinic on 15 May 2017 in relation to a thumb injury. He was given a number of treatment options which he said he would consider and agreed to be reviewed in six months.

Mr D fatally struck Mr J with a hammer on 18 May 2017.

Mr D's most recent treatment plan

A treatment plan is the approach a Trust takes to care, support and treat a patient. This can take into account numerous factors including mental health symptoms, physical health, social support, family engagement, employment and housing. We focused on Mr D's care plan, risk assessment and risk management as a means of assessing Mr D's treatment plan.

- Care plan

The Trust internal investigation noted that Mr D had a complex mental health history and that the CMHT were unaware of this. His care plan did not reflect his mental health history. Mr D's care plan in January 2017 was to stop taking Sertraline, be referred to a psychologist and be seen again by the team speciality doctor (the CMHSOP consultant psychiatrist) in four months. The care plan did not reflect a number of factors pertaining to Mr D including his isolation from his family, his propensity to disengage from services, his anxiety, and history of violence/theft and alcohol abuse. The care plan was not written in line with NICE guidelines (e.g. promoting activity) and his crisis plan was not personalised for Mr D, rather he was given generic contact numbers.

Though Mr D had a care plan in place on 30 January 2017 it was redundant in view of the CMHSOP MDT decision taken on 1 February 2017 to refer Mr D to the CMHT (i.e. Speciality Doctor 2 would not be undertaking a home visit to see Mr D in four months).

Mr D was discharged from the CMHSOP and the CMHT did not accept his referral therefore he was no longer under Trust services and did not have a care plan in place at the time of the incident in May 2017.

The Trust investigation set out that staff did not adhere to the Trust transfer policy, therefore we do not revisit this, though note that CMHSOP staff did not complete a discharge summary for the CMHT in anticipation of the latter accepting Mr D onto its caseload.

- Risk assessment and risk management

Mr D's risk assessment on 30 January 2017 did not provide a narrative of his risk formulation, nor detail a summary of his risk (e.g. historical violence) and protective factors. There was no risk management plan linked to the risk assessment.

- Treatment plan

There is evidence of the CMHSOP staff having multiple contacts – by phone and in person - with Mr D from May 2015 (the time of his last referral into the team) onwards. They responded promptly to his (or that of his GP and/or friends) phone calls for assistance and undertook home visits. For example, the team undertook a home visit on 30 January 2017 in response to a concerned friend's phone calls to the team earlier in the day and on 27 January 2017.

Mr D would sometimes disengage from Trust services and there is evidence that the team continued to try to contact him during these times. Despite these multiple contacts with Mr D, there was an absence of meaningful assessment or formulation of his mental health issues by the CMHSOP. He was seen by numerous members of staff, but there is little sense anyone was primarily responsible for managing his care, despite being under the team for nearly two years.

His care plan and risk assessment were limited in scope and we could not find evidence of a risk management plan or a personalised crisis plan. Equally the CMHSOP did not complete a transfer/discharge summary for Mr D when it referred him to the CMHT, which would have contained a clear plan for the receiving team to refer to.

Mr D had not been formally assessed therefore his care was not defined, however the CMHSOP had enough information to formulate a plan of care, which even if he refused to accept, should have been offered to Mr D and communicated to the CMHT.

There is no evidence of the CMHSOP setting out a treatment plan for Mr D, or ongoing evaluation of his care, as would be expected under Trust and national policy.

Trust internal investigation

The focus of the Trust investigation was the failure of staff to adhere to the Trust transfer policy. This was a fundamental factor in Mr D's case but the Trust report lacks detail of any analysis undertaken. We understand the Trust investigators did consider Mr D's history beyond the scope of the investigation, and met with his GP as part of this process, but this detail is not reflected in the report. The investigation report did not set out the detail of any consideration of Mr D's risk, medication, care plans, disengagement or alcohol dependence. Trust investigators were satisfied that Mr D was appropriately managed by the CMHSOP,

but gave no indication in the report of how this assessment was reached, whether practice was in line with Trust or national policy and whether issues such as Mr D's repeated disengagement and periods of substance/alcohol abuse had been comprehensively explored; all of which could have contributed to further learning. It is our understanding that Trust investigators did consider Mr D's care in the context of Trust policy and protocols, but this is not evidenced.

The Trust investigation was conducted in line with NHS England and Trust SI policy – though of limited scope - and signed off in line with Trust STEIS and CRCG SI process. However the SI report was not signed off in line with the Trust policy. The report was not reviewed by the Trust-wide Patient Safety and Mortality Review Group, the aforementioned Manager and Directors signed off the report on an individual basis, as opposed to the report being subject to a broader quality assurance process.

Trust's progress with its action plan
The Trust provided a significant amount of evidence detailing its progress with its action plan. On balance, we consider that the actions are complete but note that there are some gaps in the detail of the evidence provided.

The embedding of learning and the Trust culture of safety
There is extensive evidence the Trust has brought in a number of systems to monitor its performance against various measures and targets, and that it is taking steps to improve how it focuses on key issues (e.g. the revised QPR, CLiQ reports). In particular the introduction of 'A Day in the Life' pack was designed to ensure consistency in practice and provide staff with clarity around expected standards. The Trust is undertaking work in response to areas of concern including holding a Trust-wide Dual Diagnosis learning event, risk management workshops, dual diagnosis workshops, CLiQ checks, Choice and Partnership Approach (CaPA) model implementation and supervision.

However more evidence is required about how the Trust is addressing instances where it is not achieving its QPRs as documented in the monthly performance score card (e.g. crisis plans for all patients) and/or further concerns are identified (e.g. June – August 2018 thematic review – communication and delivery of care). For example, the IQPR performance summary showed the CRCG had not met the performance target of *CPA patients receiving a formal CPA within the past 12 months* on a monthly basis between September 2017 and August 2018 (the timeframe for the scorecard). A number of other indicators (e.g. *percentage of patients with valid CPA care plan or plan of care*) were also highlighted in red for the entire summary scorecard.

The Trust has taken steps to embed learning across the Trust however it is difficult to quantify whether this has led to improved patient safety, based on the evidence provided, and there is little evidence of learning specifically from Mr D's case. Leading from this, factors identified as part of the original SI are still being identified in themes. For example, a Patient Safety Learning evening focusing on 2017 SIs identified transfer and discharge and lack of adherence to policy as common themes across the six cases reviewed.

Adherence to Duty of Candour
The Trust did not adhere to Duty of Candour at the time of the incident because the Police asked the Trust not to contact the victim's family. This was not revisited by the Trust after Mr D's conviction in November 2017. The Trust did not contact Mr D's family before or after his trial, though we note in the context of our own investigation, NHSE have been unable to establish contact with either family.

Canterbury and Coastal CCG's quality assurance processes in relation to Mr D's case
The Trust SI was discussed at the November 2017 CCG Serious Incident Review Group (SIRG) and subsequently closed at the Canterbury and Coastal CCG Quality Committee. However the SIRG did not complete a quality checklist and there is no evidence Canterbury and Coastal CCG tested the robustness of the Trust investigation or its action plan. Canterbury and Coastal CCG's decision to close the Trust investigation was not undertaken in line with the SIRG terms of reference or NHS England's (NHSE) Serious Incident (SI) framework.

Canterbury and Coastal CCG was aware in August 2017 that the Trust had concerns in relation to how individual action plans were monitored but there is no evidence the CCG took action in response to this. There is no evidence Canterbury and Coastal CCG monitored the Trust's progress with its action plan for the SI, tested the evidence submitted, or reviewed whether the Trust had taken steps to embed learning.

Canterbury and Coastal CCG – as part of East Kent CCGs - is implementing changes to the process by which it reviews and monitors SIs and action plans, but these remain in infancy and yet to be fully implemented. However the NHSE SI framework has been in place since 2013 and the CCG should already have the systems and processes in place to monitor and review SI reports and action plans.

Recommendations

Recommendation 1: Trust SI reports should set out the evidence and analysis used to form judgements as to whether practice was undertaken in line with Trust policy.

Recommendation 2: The Trust should enforce its assurance and sign off process/policy for serious incident reports.

Recommendation 3: The Trust should review its action plan process to strengthen action sign off, specifically:

- A section in the action plan template to assign individual and/or executive team responsibility for signing off actions
- Details of executive team oversight
- The names and roles of individuals responsible for signing off actions.

Recommendation 4: The template for 'Referral not accepted' should include a signpost to copy the GP into the letter in instances when the GP was not the original referrer.

Recommendation 5: The Trust needs to further assure itself, by way of audit, that GPs, patients and referring teams are being informed of a CMHT decision to not accept a patient.

Recommendation 6: The Trust wide Patient Safety and Mortality Review Group should undertake an audit of the last 12 months of investigations to assure itself that the Trust adheres to Duty of Candour.

Recommendation 7: Canterbury and Coastal CCG should seek to assure itself, as a priority, that it is signing off Trust SI reports in line with CCG policy and the NHSE SI framework, and that Trust action plans are appropriately tested, monitored and reviewed.

2 INTRODUCTION

Mr D was 62 years old and lived alone at the time of the serious incident in May 2017. He had been married and divorced twice and had five children by his first marriage.

Mr D assaulted his neighbour, Mr J – whom he knew – on 18 May 2017. He contacted the Police the next day to report that he had struck his neighbour with a hammer and that he was concerned for his neighbour's welfare. The Police attended Mr J's address, where he was found deceased. Mr D was arrested and charged with murder the same day. He was convicted of murder in November 2017 and sentenced to a minimum of 12 years in prison.

Prior to the incident, Mr D had been seen by mental health services over a 20 year period. His most recent referral was to Kent and Medway NHS and Social Care Partnership Trust ('the Trust') secondary mental health services – Canterbury Community Mental Health Service for Older People (CMHSOP[1]) – in May 2015. He had been referred by his GP for a review and opinion about the memory difficulties he was experiencing. Mr D remained under the CMHSOP until February 2017, when he was discharged from the service to the Canterbury and Coastal Community Mental Health Team (CMHT). The CMHT did not accept Mr D's referral and he was discharged from the service the same month. The Trust had no further contact with Mr D until the Police made contact in May 2017.

NHS England (NHSE), South, commissioned Mazars to undertake an independent review of the Trust RCA investigation into the care and treatment of Mr D and its progress against the internal investigation action plan. The review extended to considering the Clinical Commissioning Group's (CCG) assurance processes in relation to the Trust's investigation and progress with its action plan.

[1] The CMHSOP provides services to service users aged over 65 with a mental health problem, and those under 65 with Young Onset Dementia

3 TERMS OF REFERENCE

The terms of reference (ToR) were drafted by NHS England. They were shared with the Trust, CCG and Mazars in advance of the review; all parties were invited to comment. NHSE wrote to Mr D to inform him of the review. The ToR were:

1. Purpose of the Review
To independently assess the quality of the level 2 Trust RCA investigation into the care and treatment of Mr D, the subsequent action plan and the embedding of learning across the trust and identify any other areas of learning for the trust and/or CCG

The outcome of this review will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

2. Terms of Reference

2.1 *Produce a full chronology of Mr D's contact with Mental Health and Primary Health Care Services to determine if Mr D's healthcare needs were fully understood and that is reflected in the most recent treatment plans.*

2.2 *Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:*

- *If the investigation satisfied its own terms of reference*
- *If the investigation was completed in a timely manner.*
- *If all root causes and potential lessons have been identified, actions and shared within the organisation.*
- *Whether recommendations are appropriate, comprehensive and flow from the lessons learnt and root causes.*
- *Review whether the action plan reflects the identified contributory factors, root causes and recommendations, and those actions are comprehensive.*
- *Review progress made against the action plan.*
- *Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety culture of trust services.*
- *Review whether the Trust Clinical Governance processes in managing the RCA were appropriate and robust.*
- *Make further recommendation for improvement to patient safety and/or governance processes as appropriate.*

2.3 *Review the trusts application of its Duty of Candour to the family of the perpetrator and the victim's family.*

2.4 *Review the CCGs quality assurance processes in relation to this incident with particular reference to:*

- *The development of appropriate recommendations*
- *The monitoring of resulting action plans and the embedding of learning across the Trust*
- *Any actions taken to share and embed learning across the local health and/or social care system.*

4 OUR APPROACH

Mazars Health and Social Care Advisory Team is a multi-disciplinary team that provides specialist independent advisory support to health and social care commissioners and providers. The review was led by Kathryn Hyde-Bales, manager in the Health and Social Care Advisory Team. Geoff Brennan, Registered Mental Health Nurse (RMHN) and Learning Disabilities (LD) Nurse provided nursing input. Mary-Ann Bruce, Director, Health and Social Care Advisory Team, oversaw the review.

NHSE wrote to Mr D to inform him of the review and seek his permission to use his clinical notes, which he gave. We wrote to Mr D to inform him of the review and offered to meet Mr D if he wished to see us. Mr D wrote to us, indicating he would like to meet. We met Mr D at the end of our review to discuss our draft report. We gave Mr D a copy of the draft report and asked him to share any comments with us.

NHSE wrote to Mr D's family and Mr J's family to tell them about the review, however they did not reply, therefore we were unable to speak to either family.

Mr D's former GP surgery provided his primary care GP notes at our request.

We submitted an information request to the Trust and Canterbury and Coastal Clinical Commissioning Group (CCG). A list of the documents review can be seen in Appendix A.

We undertook telephone interviews with five members of Trust staff and the CCG. A list of interviewees can be seen in Appendix B. We would like to thank all those involved for taking part in the interviews and for providing follow-up information as requested.

We submitted the draft report to the Trust and CCG for factual accuracy checking and comment. We submitted our final report to NHSE England in April 2019.

5 CHRONOLOGY

Mr D's GP informed the Trust internal investigation that he had engaged with mental health services over a 20 year period. Mr D's Trust medical records do not reflect 20 years of engagement with mental health services – there are lengthy gaps, both in the notes and in terms of his engagement with services. We set out below a summary of the notes we reviewed. Mr D was in regular contact with his GP – we have set out what we consider to be the salient points (for example, we have not detailed Mr D's attendances for his asthma reviews, eyesight appointments, regular blood tests and the issuing of repeat prescriptions).

1995
Consultant Psychiatrist 1, wrote to GP 1 on 23 January 1995 to advise he had seen Mr D on 18 January (the reason for the review was not recorded). Mr D told Consultant Psychiatrist 1 that he took Seroxat[2] but only Diazepam[3] helped him, and he had recently started buying it from other sources in response to his GP lowering his prescription. Mr D reported that his personal problems were primarily related to his accommodation, unemployment and lack of money. Mr D indicated that he did not want to try different antidepressant medication but he asked to be referred to Social Services for help with his housing and financial concerns. Consultant Psychiatrist 1 felt there was little he could do for Mr D (which Mr D agreed with) but advised that he return if his depression worsened. Consultant Psychiatrist 1 copied his letter to a social worker colleague with a view to Mr D's social needs being assessed and support offered as required.

Mr D was seen by Senior Registrar 1 (to Consultant Psychiatrist 1), on 7 June 1995. In his letter to Mr D's GP (dated 12 June 1995), Senior Registrar 1 set out details of Mr D's forensic history, drug and alcohol use and mental state examination. Senior Registrar 1 summarised that Mr D had a *'history of overdoses, personality problems, alcohol abuse, depression and paranoid ideas. He now has self referential overvalued ideas accompanied by obsessional and hypochondriacal thoughts and possible auditory hallucinations. He has a history of violence and theft and is receiving Valium and Codeine from the black market".* Senior Registrar 1 queried in his letter whether Mr D was abusing alcohol and other drugs. He added Mr D could have an enduring personality change following a head injury when he was 14 and that this could influence his current day presentation. He added it was possible Mr D had atypical depressive disorder or a psychotic illness. Mr D was clear that he would not take antidepressant medication. Mr D was prescribed Thioridazine[4] 100mg bd[5] (that could be increased to 200mg if appropriate) with a plan to see Senior Registrar 1 again a month later.

Mr D was (mistakenly) given a follow-up appointment to see Consultant Psychiatrist 1 on 21 June 1995. He did not attend the appointment. Consultant Psychiatrist 1 wrote to GP 1 on 3 July 1995 drawing attention to Senior Registrar 1's review on 7 June 1995. Consultant Psychiatrist 1 wrote that Mr D had an "*enduring personality problem with alcohol and benzodiazepine abuse*". He added "*there is no way we can sustain his addiction by supplying him the benzodiazepine drug*". Consultant Psychiatrist 1 discharged Mr D back to GP 1.

Mr D failed to attend a follow-up appointment with Senior Registrar 1 on 5 July 1995. Senior Registrar 1 discharged Mr D back to his GP.

[2] An antidepressant
[3] A benzodiazepine used in the treatment of anxiety, alcohol withdrawal and seizures
[4] An antipsychotic
[5] Twice a day

The Addiction Centre wrote to GP 1 on 24 August 1995 to advise that Mr D had not attended an outpatient appointment or made contact with the Centre. As a result it was concluded he no longer required help and his file was to be closed.

1996

The Addiction Centre wrote to GP 1 on 29 February 1996 to advise that Mr D had not attended his outpatients or made contact with the Centre. As a result it was concluded he no longer required help and his file was to be closed.

GP 1 referred Mr D to Consultant Psychiatrist 1 again on 12 April 1996. Senior Registrar 2 (to Consultant Psychiatrist 1), wrote to GP 1 on 7 June 1996 to advise that Mr D had not attended his outpatient appointment on 5 June but he would be offered another in view of GP 1's concerns. Senior Registrar 2 asked GP 1 to encourage Mr D to attend the appointment. Mr D failed to attend the rescheduled appointment on 3 July 1996 and was discharged back to GP 1.

Consultant Psychiatrist 1 wrote to GP 1 on 30 August 1996 to advise that for reasons unknown, Mr D had been given an appointment to see him on 21 August, but had not attended. Consultant Psychiatrist 1 said he would not be offering further appointments to Mr D unless GP 1 could provide confirmation that Mr D had said he would attend an appointment.

Registrar 1 (to Consultant Psychiatrist 1) saw Mr D on 30 October 1996 (the origin of the referral is unclear). He wrote to GP 2 the next day to advise Mr D presented as very paranoid and hearing voices. Mr D refused any medication but wished to continue with Diazepam. Registrar 1 wrote that in view of Mr D moving to GP 2's area[6] (Faversham), he would be discharged from Consultant Psychiatrist 1's service and requested that GP 2 refer Mr D to psychiatric services within his catchment area.

GP 2 referred Mr D to Consultant Psychiatrist 2, East Kent Community Team, on 14 November 1996. Consultant Psychiatrist 2 wrote to Social Services (in advance of Mr D's appointment with her team) on 10 December requesting that he be allocated a social worker to assess his immediate needs.

Mr D was seen by Senior Registrar 3 (to Consultant Psychiatrist 2), on 17 December 1996. Senior Registrar 3 described in his assessment letter to GP 2, Mr D's forensic history, noting he had been arrested multiple times for stealing, being drunk and disorderly, and theft. Senior Registrar 3 also referenced Actual Bodily Harm (citing Senior Registrar 1's letter of 12 June 1995) but added Mr D offered no further information. Senior Registrar 3 summarised Mr D as *"A 44 year-old man with a history of head injury and subsequently behavioural disturbance, alcohol abuse, anxiety and paranoid ideas. Currently he is not using any alcohol but he does suffer from delusions of reference, second-person auditory hallucinations, delusions of thought-broadcasting, and severe anxiety which causes him to be agoraphobic"*. Senior Registrar 3 prescribed Risperidone[7] 1mg daily and said he would review Mr D in three weeks. Mr D was also to be referred to the team occupational therapist for attendance in the physic garden and social group (a letter was sent 17 December).

1997

Senior Registrar 3 saw Mr D on 7 January 1997. Mr D admitted to Senior Registrar 3 that he had stolen two telephones over the Christmas period with the intention of being arrested and

[6] We believe Mr D changed GP practice at some point in 1996, but the exact date is not clear in the notes.
[7] An antipsychotic

spending the holiday period in prison. Mr D was prescribed Risperidone whilst in prison, which he said he no longer wished to take. Senior Registrar 3 prescribed Chlorpromazine[8] 100mg per night in addition to Diazepam (5mg) which Mr D was meant to take twice a day. Senior Registrar 3 arranged to see Mr D a month later on 18 February.

Mr D was seen on 11 March 1997 (it is assumed this was rescheduled from 18 February) by Consultant Psychiatrist 2 in Senior Registrar 3's absence. Consultant Psychiatrist 2 wrote to GP 2 to advise that she had discussed Mr D's Diazepam addiction with him and asked GP 2 to make arrangements for Mr D to undertake inpatient detoxification. Consultant Psychiatrist 2 wrote that she would see Mr D in two months, though GP 2 subsequently requested that this happen sooner, and an appointment was made for 22 April 1997.

Senior Registrar 3 saw Mr D on 6 May 1997. Mr D reported that he felt terrible and that he had nearly had a breakdown the previous week. He attended the appointment alone but agreed to take his wife the following week. In his summary letter to GP 2, Senior Registrar 3 reiterated Consultant Psychiatrist 2's view that Mr D should be offered inpatient detoxification.

GP 2 wrote to East Kent Health Authority (EKHA) on 9 May 1997 asking that Mr D be considered or funded for inpatient detoxification. GP 2 outlined that Mr D had a long history of Diazepam addiction and had experienced considerable problems in the past when trying to stop taking it, becoming violent with paranoid beliefs. GP 2 received a response dated 15 May 1997 advising that the referral should be directed elsewhere in the first instance and was given provided the necessary details according to whether it was alcohol or drug services that were required. The author of the letter wrote that if Mr D met the relevant conditions he would be referred to the most appropriate detoxification centre.

Senior Registrar 3 reviewed Mr D in the presence of Mr D's wife on 10 June 1997. In his assessment letter to GP 2, Senior Registrar 3 said Mrs D had said her husband's outbursts were continuing and becoming serious. She said he had been convinced the previous Sunday that people on the television were talking about him and that she'd had to seek help from their neighbours. Senior Registrar 3 wrote that it was difficult to 'disentangle' Mr D's symptoms because of his ongoing abuse of Diazepam. He added that when Consultant Psychiatrist 2 had last seen Mr D she concluded further psychiatric assessment and treatment was impossible if Mr D continued to take Diazepam. Senior Registrar 3 told Mr and Mrs D that he would need to be referred by his GP to Drug and Alcohol services. Senior Registrar 3 concluded that once Mr D had stopped taking Diazepam the team would seek to help him if they could.

GP 2 referred Mr D to Drug detoxification services on 8 July 1997[9]. He provided details of Mr D's latest review by the psychiatric team and noted Mr D had failed inpatient detoxification on at least two occasions. GP 2 added that Mr D's mood could fluctuate 'wildly' and that he had been violent in the past.

GP 2 wrote to Mr D on 11 July querying if he had been taking more Diazepam recently in view of his recent prescription request being submitted earlier than usual. He asked Mr D to make an appointment to see him. There is no evidence this happened.

1998

GP 2 referred Mr D to detoxification drug services on 27 July 1998 for treatment of his Diazepam abuse. He referenced Consultant Psychiatrist 2's assessment that Mr D's

[8] An antipsychotic

[9] It is unclear from the notes whether Mr D was offered and appointment, and if so, whether he attended.

auditory hallucinations were secondary to his Diazepam abuse. GP 2 noted that Mr D had tried to stop taking Diazepam in the past during which time his auditory hallucinations had worsened and he had become violent, particularly towards his wife.

Drug services made appointments for Mr D in July and August 1998 but he failed to attend . Drug services wrote to GP 2 to advise they would not be offering Mr D another appointment[10].

1999

GP 2 referred Mr D to the Ear, Nose and Throat (ENT) department at Kent and Canterbury Hospital in May 1999 for treatment of hearing loss. Mr D did not attend the appointment. GP 2 re-referred Mr D in December 1999.

2000

Mr D was seen by the ENT service in April 2000 and referred for an MRI. The MRI scan result was normal. It was noted that his hearing in his right ear was good, but poor in his left, but there were no treatment options for this.

The Citizen's Advice Bureau contacted the Duty Mental Health team[11] on 27 September 2000. Mrs D had attended the Citizen's Advice Bureau seeking help in relation to Mr D. The Duty worker spoke to Mrs D who outlined her concerns and said she was frightened for her safety because Mr D had become very unpredictable. It was agreed that Mr D should be referred to the CMHT and he was referred the next day. GP 3 wrote to Consultant Psychiatrist 2 on 29 September 2000 thanking her for agreeing to see Mr D urgently on 3 October 2000. GP 3 noted that Mr D had last been seen by Consultant Psychiatrist 2's team in 1997 when detoxification was raised, though there was no evidence this happened. GP 3 noted that Mr D could be aggressive towards his wife and there was a history of violence. Mr D was described as coherent and well dressed, but problems concerning his behaviour seem to have arisen whilst his usual GP, GP 2, was away.

A Duty Social Worker completed a risk assessment[12] for Mr D on 28 September 2000. It noted Mr D had a history of alcohol abuse, violence and making threats, and that his Probation Order had expired two weeks previously. The notes indicate that telephone calls were held with the Probation Service and Mr D's GP.

Mr D was seen with his wife by Consultant Psychiatrist 2 on 3 October 2000. Consultant Psychiatrist 2 noted that she had seen him several times previously though he had missed his emergency appointment the previous week because she had '*got his back up*' the last time they met. Mr D's mood had not improved since his previous appointment though he was reportedly drinking less. Mr D's wife advised that when he went out drinking she would often be contacted by a friend or the Police asking that she collect him. Mr D's wife said that there had been violence between them and at times she was very frightened of him. Mr D was noted to be taking Diazepam, Chlorpromazine and Kemadrin[13]. Consultant Psychiatrist 2 advised Mr D that he should be assessed by Mount Zeehan (an alcohol recovery/detoxification unit).

[10] There is a handwritten note on the letter dated 24 August 1998 that says Mr D had been arrested. It is unclear who added this to the letter and when.
[11] Mr D's notes at this time are handwritten. A number of pages are undated therefore the chronology within the notes is difficult to follow.
[12] It is unclear from the notes whether Mr D was assessed on 28 September 2000. The handwritten notes contain a considerable amount of detail, however the pages are not numbered, sometimes difficult to read and are unsigned.
[13] An anticholinergic used to treat Parkinson's and involuntary muscle spasms

2001
Mr D was referred[14] to mental health services[15] on 30 August 2001. The screening form recorded that Mr D could potentially be violent.

Mr D was sent an appointment letter on 18 October 2001. He was offered an appointment with Consultant Psychiatrist 2 on 4 December 2001.

Mr D was seen by Consultant Psychiatrist 2 on 5 December 2001 (it is unclear why this appointment was a day later than originally scheduled). Mr D was noted to be living in a hostel in December 2001 having separated from his wife. He was reportedly drinking half a bottle of brandy a day and felt victimised. Mr D agreed to be referred to Mount Zeehan with a view to addressing his alcohol and substance misuse.

Consultant Psychiatrist 2 wrote to Consultant Psychiatrist 3 at Mount Zeehan Unit on 5 December 2001. In her letter she explained that Mr D had previously been referred to the service. She wrote that Mr D remained ambivalent about attending Mount Zeehan and that he now lived in a homeless centre having separated from his wife. Consultant Psychiatrist 2 asked Consultant Psychiatrist 3 to offer Mr D an assessment given that she felt it was not possible to assess Mr D's underlying mental state whilst he continued to abuse drugs and alcohol.

Consultant Psychiatrist 2 wrote to the local Housing Association the same day asking that they consider transferring Mr D's housing from a homeless hostel which she considered would continue to trigger and perpetuate his problems.

Mr D was written to by, SHO 1 (to Consultant Psychiatrist 3) on 7 December 2001. An appointment had been arranged for Mr D to be assessed at Mount Zeehan on 7 January 2002. The letter advised Mr D that if he did not confirm his attendance it would be assumed he would not be attending,

2002
Swale Housing wrote to GP 2 on 3 January 2002 to advise that Mr D would be housed shortly.

SHO 1 wrote to Consultant Psychiatrist 2 on 8 January 2002 to advise that Mr D had not attended his appointment on 7 January 2002 and the service did not intend to offer Mr D a further appointment. Consultant Psychiatrist 2 was advised to re-refer Mr D if she thought an appointment would be beneficial for Mr D.

2003
SHO 2 (to Consultant Psychiatrist 2), referred Mr D to the community psychotherapy department for Cognitive Behaviour Therapy (CBT). Consultant Psychiatrist/Psychotherapist 4, wrote to SHO 2 on 7 July 2003 to advise that the service did not offer CBT and the referral had been forwarded to the Psychology department.

GP 2 referred Mr D to orthopaedics and rheumatology on 14 April 2003 about his knee pain. He was seen in October and November 2003, respectively.

[14] It is unclear from the paperwork who referred Mr D
[15] The Screening form did not specify which mental health team he was being referred to.

There are no records to indicate that Mr D engaged with mental health services between 2004 and 2006.

2006

The Citizen's Advice Bureau faxed GP 4 on 5 September 2006 to report that Mr D's wife had visited them to say she was very concerned about his mental health. Mrs D reported he had stopped taking his medication and had stopped washing. He had been arrested (and released) by the Police for putting an axe through his neighbour's door and that he might be hearing voices and suffering from delusions. The fax said that it was understood Mr D had an appointment with GP 4 that week and asked that Mr D be referred for mental health support though a handwritten note on the fax said he did not have an appointment booked (it is unclear who wrote the note).

GP 2, referred Mr D to Canterbury and Coastal CMHT on 25 October 2006. The reason for referral was *"withdrawing from social contact. Recurrence of auditory hallucinations. Suicidal thoughts"*. The referral said that Mr D had a Benzodiazepine[16] addiction and had been taking them for 30 years. He would not consider reducing his intake. Mr D's risk factors were noted to be a risk of suicide or self-harm, and, possible risk of harm to others. GP 2 wrote that Mr D had allegedly been violent towards his partner in the past.

The CMHT wrote to Mr D on 8 November 2006, offering him an appointment with Consultant Psychiatrist 5 (Intake team), on 13 November 2006. Mr D did not attend. The CMHT wrote again to Mr D on 24 November 2006 offering him an appointment on 4 January 2007.

2007

Mr D did not attend the appointment with Consultant Psychiatrist 5 on 4 January 2007. The CMHT offered Mr D a third appointment for 18 January 2007 which he cancelled. Mr D indicated he was happy to only see his GP therefore the CMHT discharged him back to GP 2 on 17 January 2007.

GP 2 referred Mr D for brief intervention counselling. He was assessed by KCA Kent Primary Health Care Services on 18 September 2007. Mr D's CORE (Clinical Outcomes in Routine Evaluation) score was 31.2 which put him in the severe level clinical range in terms of psychological distress; the cut off for the service was a score of ten. Mr D also scored 15 out of a possible 24 in the risk category indicating a high level of suicidal ideation. GP 2 was advised that Mr D would not be accepted into the service and that he should be referred again to the CMHT.

GP 2 referred Mr D to the CMHT on 27 October 2007. He wrote that Mr D was increasingly withdrawn and anxious, showing symptoms similar to those in his referral sent in October 2006. GP 2 noted Mr D repeatedly failed to attend appointments and that he had been seen by a KCA (drug services) counsellor who was unable to help (the letter from the KCA was provided in the referral).

An appointment was made for Mr D to see Consultant Psychiatrist 2 on 27 November. He contacted the service to request he be seen by another Consultant Psychiatrist. Another appointment was made for Mr D to see Consultant Psychiatrist 6 (Intake Team) for brief allocation and help, the next day.

Consultant Psychiatrist 6 wrote to GP 2 on 3 December 2007 detailing his assessment of Mr D who he had seen on 28 November. The heading of the letter was '*Diagnosis Possible*

[16] Benzodiazepines are psychoactive drugs typically used in the treatment of anxiety and as a sedative

Social Phobia; history of depression, low mood and history of harmful use of alcohol". Consultant Psychiatrist 6 detailed Mr D's complaints and that he reported feeling very low and depressed. Consultant Psychiatrist 6 noted Mr D had experienced an unpleasant past and abusive childhood, and that he was not in contact with his family (including his children, all of whom were adult age). Consultant Psychiatrist 6 wrote *"I believe this man may have suffered from mild moderate depressive illness on the background of social isolation and phobia and history of alcohol"*. Consultant Psychiatrist 6 asked that the practice nurse give Mr D a blood test[17]. He advised he had prescribed Cipralex[18] 5mg to be taken daily, would see Mr D again in six weeks and refer him to the Intake Team for brief allocation and help.

Social Worker 1 for the Intake Team, wrote to Mr D on 11 December 2007 offering him an appointment on 18 December 2007. It is unclear whether Mr D attended the appointment.

2008

Social Worker 1, wrote to Mr D on 3 April 2008, noting a colleague had visited him on 31 March, and asking whether he required further help or was happy to be discharged back to his GP.

Social Worker 1, wrote to Mr D on 28 April 2008 to advise that given she had not heard from him, she was discharging Mr D back to his GP.

GP 5 saw Mr D on 27 August 2008. Mr D said he was not taking his medication regularly and felt confused. Mr D indicated he needed more support managing his finances. He denied excessive alcohol intake or suicidal ideation. Mr D was issued a repeat prescription of Escitalopram[19] 10mg.

An appointment was made for Locum Consultant Psychiatrist 1 to undertake a home visit to see Mr D on 11 November 2008. Mr D was not home. Locum Consultant Psychiatrist 1 wrote to Mr D the same day to say he should get in touch to make another appointment. Locum Consultant Psychiatrist 1 advised that if Mr D did not make contact within four weeks it would be assumed he did not want to be seen and would be discharged back to his GP.

2009

GP 6 saw Mr D on 8 January 2009. He was complaining of chest pains. He reported his father had died of a heart attack. Mr D's chest was clear and reported no specific timing or pattern to his chest pain. He was advised to go to hospital if the pain got worse.

GP 6 reviewed Mr D's medication with him on 5 October 2009. Mr D said he was unable to come off antidepressants. He had tried in the past and experienced withdrawal symptoms. Mr D said he was experiencing back pain, having fallen and hit the edge of his coffee table, the day before. GP 6 advised Mr D to take paracetamol.

2010

GP 7 referred Mr D for physiotherapy and for an x-ray on 10 March 2010 (the results of the latter were later reported as normal and Mr D was subsequently scheduled to have a CT scan).

[17] For thyroid function, full blood count, liver function and Gamma GT
[18] An antidepressant
[19] An antidepressant. Mr D was prescribed Escitalopram throughout 2009 and 2010. His last repeat prescription was issued on 20 September 2010

Consultant Rheumatologist 1 wrote to GP 7 in June 2010[20]. Consultant Rheumatologist 1 noted that Mr D had had x-rays, a CT scan and an MRI scan of his neck. Consultant Rheumatologist 1 noted that Mr D's neck and back pain should respond to physiotherapy and he was aware surgery had been arranged for Mr D. Consultant Rheumatologist 1 advised he did not think he needed to follow up with Mr D, though the MRI report referenced neurological opinion, which he assumed GP 7 was arranging.

GP 7 referred Mr D to neurology on 6 July 2010.

GP 8 saw Mr D on 25 August 2010. Mr D was experiencing lower back pain. He was referred to physiotherapy.

GP 9 saw Mr D on 31 August 2010. He was noted to be a moderate drinker, consuming three to six units a day. Mr D was experiencing pain in his neck and arms. Mr D was prescribed pain medication and advised to wait for his appointment with neurology.

Mr D was seen by Consultant Neurologist 1 in October 2010. In his letter to GP 7, dated 19 October 2010, Consultant Neurologist 1 noted that Mr D had a history of head injury and that at the age of 21 he had experienced a loss of consciousness and undergone decompressive surgery because of intracerebral bleeding. Mr D also had a fall in 2009 when he hit his neck and was in quite significant pain. Consultant Neurologist 1 said his examination revealed no need for further immediate follow up, but that he was requesting an MRI scan[21].

2011

Social services contacted Mr D's surgery on 8 April 2011 to say that a carer for Mr D had reported (at 1620hrs) that Mr D was very depressed and felt like killing himself. GP 2 telephoned Mr D the next day. He said he was felling low and had had a letter from his solicitor about a claim for abuse[22].

GP 2 saw Mr D on 15 April 2011. Mr D was noted to be '*aching all over'*, experiencing poor sleep and poor concertation. He had reduced his alcohol intake. GP 2 increased Mr D's Sertroline to 50mg and 100mg for his anxiety/depression

GP 2 described Mr D's alcohol consumption of 70 units a week, in his notes on 12 September 2011, as 'hazardous'.

Mr D was seen by Consultant Neurologist 1 for a follow-up appointment on 12 May 2011. Mr D had a normal neurological examination and had no further symptoms of concerns, and was therefore discharged back to GP 2.

GP 2 changed Mr D's Sertraline prescription to 100mg, twice daily, on 19 August 2011.

Mr D attended a physiotherapy appointment on 19 October 2011.

Mr D was seen by GP 2 on 3 November 2011. He had been experiencing alcohol induced hallucination and continued to experience shoulder pain. Mr D was advised to contact alcohol services for help. GP 2 referred Mr D on 5 December 2011 to orthopaedics for review of his shoulder pain.

[20] The letter is dated 'dictated 14 June 2010'. The date it was sent is unclear.
[21] The MRI was carried out (it is referenced in the subsequent letter from Consultant Neurologist 1 dated 18 May 2011, detailing Mr D's 12 May 2011 appointment) but we do know on what date.
[22] No further detail is provided in the notes.

Physiotherapist 1 saw Mr D on 9 November 2011 for a physiotherapy follow-up. Mr D reported his right arm and shoulder continued to cause him considerable pain and were impacting his ability to sleep. It was noted that physiotherapy was not helping Mr D. He was referred back to his GP with a view to him being considered for an injection into his shoulder and referred to rheumatology.

Mr D's prescription of Sertraline changed to 50mg, once a day on 5 December 2011.

2012

Specialist Registrar (SpR) 1 (for Consultant Orthopaedic Surgeon 1), saw Mr D on 12 January 2012. He gave Mr D an injection of local anaesthetic and steroid in his shoulder which relieved his pain. SpR 1 arranged an MRI scan for Mr D's left shoulder and said he would see him again with the results in a few months.

Mr D did not attend his appointment with Consultant Orthopaedic Surgeon 1 on 8 March 2012.

GP 10 reviewed Mr D on 21 March 2012. Mr D reported ongoing pain and that he was not sleeping. Mr D's Sertraline was increased to 100mg[23].

SpR 1 saw Mr D on 22 March 2012 with his MRI results. He gave Mr D another shoulder injection. Following a discussion it was agreed that Mr D would be added to the waiting list for a left shoulder arthroscopy, subacromial decompression and rotator cuff repair.

GP 5 saw Mr D on 1 June 2012. He was experiencing pain in his neck and shoulder and was scheduled to have an MRI the following week. Mr D asked for tramadol, codeine and sleeping tablets. GP 5 advised that a steroid injection would be more effective however Mr D declined.

SpR 1 reviewed Mr D on 7 June 2012. He gave Mr D another subacromial injection and said he remained on the waiting list for surgery.

Mr D had surgery on his shoulder on 16 July 2012.

GP 11 discussed Mr D's blood results with him on 12 September 2012. GP 11 advised that Mr D should reduce his alcohol intake.

GP 2 saw Mr D on 25 September 2012. Mr D reported ongoing pain in his right knee.

GP 2 saw Mr D on 23 October 2012. Mr D said he had cut down his alcohol consumption. GP 2 issued Mr D's repeat prescriptions (e.g. Sertraline 50mg tablets and Diazepam 10mg tablets as required).

GP 2 increased Mr D's Sertraline prescription to 100mg on 12 November 2012.

2013

GP 2 saw Mr D on 16 April 2013. Mr D's anxiety had worsened but he did not want to increase his Sertraline[24] prescription.

[23] Mr D's Sertraline prescription was changed to 50mh, once a day, on 3 April 2012.
[24] An antidepressant

GP 2 saw Mr D on 12 August 2013. Mr D's depressed mood had worsened recently and he had stopped taking Sertraline. He reported a poor appetite and that he lacked motivation. GP 2 increased Mr D's Sertraline prescription to Sertraline 50mg and 100mg, both to be taken daily.

GP 12 saw Mr D on 20 September 2013. Mr D was noted to be drinking 210 units a week. Mr D indicated he wanted help to reduce his alcohol use. He was advised to gradually reduce his intake. Mr D said he had stopped taking Sertraline because he felt 'lazy' on them. Mr D indicated he did not like Alcoholics Anonymous, but was willing to attend local drug and alcohol support services. Mr D's Sertraline prescription was changed to 100mg, daily.

Mr D was admitted to Kent and Canterbury Hospital on 1 November 2013, experiencing abdominal pains and a minor head injury. He was referred to the East Liaison Psychiatry Service. It was recorded that Mr D abused alcohol and was addicted to Diazepam. Mr D was referred to Turning Point (a drug and alcohol support service) and given information about the service/contact details.

GP 2 saw Mr D on 28 November 2013. Mr D was not taking his Sertraline but reported his mood had improved and he was not drinking alcohol. Mr D said he was attending Turning Point and was feeling more positive. Mr D was still taking Diazepam for his anxiety.

2014

Mr D was seen by the Community Orthopaedic Service on 3 February 2014 in relation to his neck pain. He was referred for an MRI with a view to being reviewed once the results were available.

GP 2 prescribed Mr D 50mg Sertraline on 25 March 2014 for anxiety and depression. Mr D continued to be prescribed Diazepam.

GP 7 authorised a repeat prescription of 50mg Sertraline for Mr D on 26 June 2014.

GP 2 prescribed Mr D 50mg Sertraline on 8 July 2014 for anxiety and depression.

Mr D was seen by Healthcare Assistant 1 on 18 August 2014 for a surgery consultation. Mr D said he was drinking 98 units of alcohol a week and wanted to see a GP. He said he was very depressed and had experienced a bad childhood.

Mr D was seen by GP 13 on 29 August 2014 for chest pain. GP 13 referred Mr D to the chest pain clinic the same day and advised him to call 999 if he experienced further chest pain.

GP 2 prescribed Mr D 100mg Sertraline tablets on 5 September 2014.

Mr D was reviewed by Consultant Cardiologist 1, at the 'fast-track angina evaluation clinic' on 11 September 2014. Consultant Cardiologist 1 concluded that Mr D might have angina but his symptoms could be respiratory in origin. Consultant Cardiologist 1 recommended that Mr D have an angiogram and echocardiogram.

GP 2 saw Mr D on 28 October 2014. Mr D had a cough and discussed the death of his son. He reported poor sleep, headaches, difficulty coping and that he was hearing voices. He said he felt suicidal but had no active intent to commit suicide. Mr D said he was not drinking. GP 2 changed Mr D's prescription to 50mg Sertraline

GP 2 undertook an interim review of Mr D's depression on 18 November 2014. His mood was noted to not be any better and his Sertraline was increased from 50mg to 100mg.

GP 2 wrote a letter (recipient unknown) on 24 November 2014 advising that Mr D suffered from longstanding anxiety and depression, neck pain, possible angina and asthma. GP 2 asked that these factors be taken in account when assessing Mr D's eligibility for benefits.

Mr D attended the GP surgery on 8 and 24 December 2014 for treatment of a cough.

East Kent Hospitals University NHS Trust cardiac services wrote to GP 7 on 10 December 2014 to advise Mr D had requested to be removed from their waiting list to see Consultant Cardiologist 1 because he was feeling better.

2015

Consultant Cardiologist 1 saw Mr D at his cardiac outpatient clinic on 27 January 2015[25]. He noted (in his letter to GP 7 dated 30 January 2015) that Mr D's symptoms persisted and that he would not reduce his smoking. He prescribed Ivabradine[26] 5mg bd and listed Mr D for an angiogram and echocardiogram.

Consultant Cardiologist 1 wrote to GP 7 again on 28 January 2015 to advise that he had been informed Mr D had failed to attend his echocardiogram and cancelled his angiogram due to ill health. Consultant Cardiologist 1 wrote that it would not be possible to progress Mr D's cardiac management without the investigations and requested that GP 7 re-refer Mr D to cardiology if the need arose.

GP 9 saw Mr D on 9 March. We was experiencing chest pains. Mr D's chest was clear and was advised to stop smoking.

Mr D had an angiogram on 13 April 2015, the result of which was normal. GP 14 saw Mr D on 24 April 2015. He was experiencing bilateral knee pain which had been an ongoing problem for a number of years. Mr D was prescribed co-codamol and referred to physiotherapy.

GP 14 saw Mr D on 1 May 2015. He noted that Mr D had a long history of worsening memory and that he was starting to forget if he had taken his medication and attend some appointments. GP 14 referred Mr D to secondary mental health services for a review and opinion regarding his memory difficulties. In his referral letter, GP 14 requested that Mr D be seen in view of his worsening memory. The Canterbury Community Mental Health Service for Older (CMHSOP) Memory Clinic telephoned Mr D on 18 May to arrange an appointment for him at the memory assessment clinic. The CMHSOP sent Mr D an appointment letter on 20 May 2015 for an assessment on 9 June 2015. Mr D was provided with a pre-assessment questionnaire to complete in advance of the appointment. The letter set out that he would be seen by a nurse, occupational therapist or doctor.

Mr D attended his GP surgery on 11 May 2015 complaining of knee pain, which he said he'd had for a long time but had recently gotten worse. Mr D was referred to physiotherapy.

Mr D missed his appointment with physiotherapy on 1 June 2015.

[25] It is unclear how this appointment happened given Mr D's contact at the end of 2014, saying he wished to be removed from the waiting list.
[26] Medication used in the treatment of heart conditions

Mr D attended his GP surgery for a memory assessment with CMHSOP on 9 June 2015. He described his memory as 'awful'. Mr D told the assessing member of staff about his difficult childhood in Ireland and that as an adult he had been in prison and experienced periods of homelessness. Mr D said that he had used a variety of drugs in the past and presently drank 3 pints a day and smoked marijuana on occasion, most recently, the previous night. Mr D said he felt lonely and depressed.

Mr D's memory was assessed and an ACE-111 (Addenbrooke's Cognitive Examination[27]) completed. He scored 73/100 with sub scores of 14/18 for Attention, 16/26 for Memory, 7/14 for fluency, 23/26 for language and 13/16 for visuospatial. The assessing staff and Mr D discussed the possible reasons for his memory difficulties including stress, grief, depression, medication, drugs and alcohol. The plan was for Mr D to be referred for an MRI head scan to see if there was any evidence of alcohol related damage or any neurodegenerative change. Mr D was to be followed up by a doctor in the team to discuss his depressed mood and poor memory. A referral for an MRI was sent the next day.

GP 14 saw Mr D on 15 June 2015. He had recently stopped taking Sertraline and was experiencing palpitations in the morning. Mr D otherwise felt well, but was concerned whether he should start taking the antidepressant again.

The CMHSOP wrote to Mr D on 24 August 2015 to offer him an appointment with Consultant Psychiatrist 7 (for older people), on 22 September 2015. There is no evidence in the notes to suggest this appointment took place.

Mr D had an MRI on 10 September 2015. The radiological report said "…*no evidence of vascular malformation*. *There are a number of small high signal foci within the superficial white matter of the frontal lobes in particular, consistent with the ischaemic effects of small vessel disease. There is no evidence of acute or chronic haemorrhage".*

Mr D attended his GP surgery on 6 October 2015 for treatment of a cough.

GP 15 saw Mr D on 10 November 2015. He was experiencing lower back pain and rectal bleeding. Mr D was noted to be chatty and walking unaided with a slight limp. Mr D's alcohol consumption was 42 units a week which he was advised to reduce.

Mr D attended his GP surgery on 17 November 2015. He was experiencing sciatica. Mr D was advised to use ice packs and attend the surgery the following week for a GP review.

Mr D was seen by GP 16 on 19 November 2015. He was experiencing back pain and sciatica. Mr D had had back pain for four weeks and was experiencing constant pain the length of his right leg. Mr D was referred to a physiotherapist.

Mr D was seen by Nurse Practitioner 1 on 24 November 2016 for his back pain. Mr D reported it was an ongoing problem and that his pain was not well controlled. He was experiencing lower back pain that radiated to his right leg, down to the ankle. Mr D was noted to be walking reasonably easily and was not experiencing any bony tenderness. Mr D was prescribed co-codamol and was scheduled to see physiotherapy two days later.

Mr D's back pain was reviewed at his GP surgery by Physiotherapy on 26 November 2015. Mr D was scheduled for a further review three weeks later.

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[27] *"The Addenbrooke's Cognitive Examination – III (ACE-III) is a brief cognitive test that assesses five cognitive domains: attention, memory, verbal fluency, language and visuospatial abilities… The total score is 100 with higher scores indicating better cognitive functioning."* http://www.Dementia.ie/images/uploads/site-images/ACE-III_Scoring_(UK).pdf

Mr D was taken by ambulance to hospital on 29 November 2015 for symptoms of breathlessness and pain[28].

Consultant Psychiatrist 7 (CMHSOP) wrote to Mr D on 2 December 2015 asking that he contact the service with a view to arranging an appointment. Consultant Psychiatrist 7 wrote that Mr D had been unable to attend the previous appointment that had been scheduled to take place on 17 November.

Mr D attended his GP surgery with a mild eye infection on 9 December 2015.

The CMHSOP wrote to Mr D on 21 December 2015 offering him an appointment with Consultant Psychiatrist 7 on 15 January 2016.

Mr D was reviewed by Nurse Practitioner 1 at his GP surgery on 22 December 2015 for his lower back pain and pain in his right leg. Mr D appeared bright and chatty. He said he was not taking his pain medication. Nurse Practitioner 1 provided advice about pain management and recommended that Mr D make an appointment with physiotherapy.

The CMHSOP contacted Mr D on 23 December to remind him of his appointment scheduled for 15 January 2016. Mr D confirmed he was happy to attend.

2016

GP 2 undertook a telephone consultation with Mr D on 4 January 2016. Mr D was experiencing lower back pain and had attended one session with physiotherapy. GP 2 prescribed co-codamol.

Mr D was seen by Consultant Psychiatrist 7 on 15 January 2016. Consultant Psychiatrist 7 did not think Mr D's memory problems were due to a neurodegenerative condition and considered there could be many reasons for it, including poor schooling, a long history of depression and anxiety, drug and alcohol misuse and a history of head injuries. Consultant Psychiatrist 7 noted that Mr D's ACE-III score was *'well below'* the cut off for dementia. Consultant Psychiatrist 7 considered Mr D's anxiety to be the primary cause at that time. The plan was for Mr D to be referred for neuropsychological assessment and that Consultant Psychiatrist 7 would review him again, thereafter.

GP 2 telephoned the CMHT on 23 February 2016. He said he had concerns about Mr D who had attended the surgery that morning. Mr D was more negative and angry than GP 2 had previously seen. GP 2 wanted to check that the team had a copy of Consultant Psychiatrist 7's assessment as Mr D did not want to have to repeat his history. GP 2 advised that Mr D was Benzodiazepine dependent and was taking 10mg tablets a week, PRN[29]. GP 2 said that previous attempts to reduce this had resulted in Mr D becoming severely unwell, bordering on signs of psychosis. GP 2 faxed an urgent referral to the CMHT the same day.

GP 2 also faxed Mr D's referral to Canterbury CMHSOP on 26 February 2016. Mr D was described in the referral as feeling low and angry with some thoughts of self harm. A member of the CMHSOP telephoned Mr D who indicated he was happy to have a discussion over the phone. Mr D said he was still experiencing thoughts of self harm but did not intend to act on these. Mr D said he had a follow-up appointment with Consultant Psychiatrist 7 scheduled for 19 April 2016. They agreed that the CMHSOP would look to bring the

[28] It is not possible to ascertain the full detail of the ambulance service assessment due to the notes being faded.
[29] *Pro re nata* – as needed

appointment with Consultant Psychiatrist 7 forward and that the Duty team would contact Mr D after the weekend. Mr D was given the crisis team contact details. Mr D's appointment with Consultant Psychiatrist 7 was brought forward to 22 March 2016.

Duty Officer 1, CMHSOP, contacted Mr D on 29 February 2016. Duty Officer 1 found it difficult to understand Mr D's accent though it was noted Mr D was feeling low and that things had built up emotionally. Mr D was told his appointment with Consultant Psychiatrist 7 had been brought forward. Mr D said he felt things were going OK and that he would contact the team if he needed. He said he was willing to be referred to Age UK. Duty Officer 1 completed a referral to the local Age UK and removed Mr D from the RAG board as he was no longer in crisis.

Psychological Services for Older People sent Mr D a letter on 3 March 2016 offering him an appointment with, Clinical Psychologist 1 (Older Peoples' Services), and Assistant Psychologist 1 on 15 April 2016.

Mr D's friend called the CMHSOP on 8 March 2016 to confirm the date and time of Mr D's appointment with Consultant Psychiatrist 7. The friend reported Mr D had had some episodes of verbal aggression but these were manageable. The friend indicated that he and Mr D had the team's contact details if he became unwell and that he would be accompanying Mr D to his appointment with Consultant Psychiatrist 7 later in the month.

Mr D was seen by Specialty Doctor 2 (to Consultant Psychiatrist 7), on 22 March 2016. He attended alone and reported that he had been feeling 'terrible' since his last visit and that his memory was 'terrible'. Mr D had stopped taking Sertraline three to four months previously but indicated that he was going to see his GP with a view to restarting it. Mr D was noted to be taking 60mg-80mg Diazepam daily and drinking a can of alcohol every day. He said he had previously been alcohol dependent but had been to rehab. The plan was for Mr D to visit his GP with a view to restarting his Sertraline and that he attend the previously arranged neuropsychological assessment scheduled to take place on 15 April 2016. They agreed that Mr D would be reviewed in six months.

GP 2 saw Mr D on 23 March 2016. They discussed Mr D's benefits. Mr D asked if he could be exempted from his council tax. GP 2 advised Mr D to contact the Citizen's Advice Bureau for information.

GP 9 saw Mr D on 30 March 2016. Mr D was experiencing sciatica which he reported had started six weeks previously. It was recorded in the notes that Mr D's depression was getting a 'little better' and that he was taking his medication.

GP 16 saw Mr D on 8 April 2016. He was experiencing sciatica and pains in his left leg, sacrum area, radiating to the groin. He was prescribed Lansoprazole[30] and Naproxen[31].

Mr D left a message with the CMHSOP on 12 April 2016 to cancel his neuropsychological assessment scheduled to take place three days later. Mr D was offered an appointment on 22 April 2016 (confirmed in a letter sent 14 April) but he did not attend.

GP 17 telephoned Mr D on 14 April 2016 (it is not clear what prompted this call, but assumed Mr D had made contact earlier). Mr D was experiencing neuralgic pain shooting to his left testicle. GP 17 offered Mr D an appointment that day, but Mr D declined. An appointment was made for the next day.

[30] Medication used to treat indigestion, heartburn and acid reflux
[31] An anti-inflammatory

Mr D was seen by GP 18 on 15 April 2016. Mr D reported he was experiencing sciatica and that pain killers were not helping. Mr D was given a diclofenac[32] injection.

Mr D did not attend a physiotherapy appointment on 21 April 2016.

Consultant Psychologist 1 called Mr D on 27 April to ask why he didn't attend his appointment and whether he still wanted to be seen. Mr D was distressed and the call lasted roughly 25 minutes at which point they were cut off. Consultant Psychologist 1 tried to call Mr D again but the line was busy. Consultant Psychologist 1 contacted the Duty team to ask that it follow up with him that day.

Mr D telephoned his GP surgery on 9 May 2016. He said he was experiencing lower back pain. He said he had not attended an appointment with physiotherapy as he knew it would not help. Mr D spoke to GP 19 who advised that he reengage with physiotherapy and prescribed Naproxen. GP 19 told Mr D that ongoing diclofenac injections were not a solution.

Mr D did not attend a scheduled appointment with Community Psychiatric Nurse (CPN 2) with the CMHSOP on 10 May 2016. CPN 1 tried to contact Mr D but had no response.

Consultant Psychologist 1 wrote to Mr D on 13 May 2016. Consultant Psychologist 1 set out the details of the two appointments Mr D had been offered with the psychology service and that in view of his decision to not attend either appointment, her decision was to not offer Mr D another appointment. She directed Mr D to his GP or the community team should he wish to be seen at another time.

Mr D attended his GP surgery on 17 May 2016. He had thought he had an appointment with the mental health team that day, but did not. He became agitated and left.

CPN 1 tried to contact Mr D again on 18 May 2016. Mr D initially answered but the call was then cut off. He did not answer further attempts to call him. In view of Mr D's failure to attend appointments and a number of cancelled appointments, no further arrangements were made to see him. It was noted that Mr D had a follow-up appointment with Speciality Doctor 2 scheduled in September 2016.

Mr D sent a copy of Consultant Psychologist 1's letter back to the Trust which was received on 19 May. Mr D had written a number of comments on the letter and added a further page of commentary. It is not clear if the letter was addressed to a specific individual though CPN 1's first name was written at the top of the letter.

Mr D was taken by ambulance to A&E on 19 May 2016. His presenting complaints were a head injury and alcohol use. It was recorded in the triage notes that Mr D had fallen against a brick wall and been knocked out. His examinations were normal and he was discharged home with advice.

Mr D telephoned his GP surgery on 20 May. He spoke to GP 2, telling him he had fallen from a wall the previous day and had hit his head on some bricks. He had attended A&E but did not have a scan. Mr D said he had been vomiting since the night before and had a headache. GP 2 advised Mr D to attend A&E if the vomiting persisted or he began to feel worse.

Mr D attended his GP surgery on 24 May 2016, complaining of lower back pain.

[32] An anti-inflammatory

Consultant Psychologist 1 wrote to Mr D on 26 May to advise that someone would contact Mr D shortly to arrange a home visit. The letter was copied to CPN 1, Consultant Psychiatrist 7, Speciality Doctor 2 and GP 5.

Mr D telephoned his GP surgery on 31 May 2016. He spoke to GP 2, saying he was experiencing back pain which co-dydramol[33] was not addressing. GP 2 prescribed Tramadol.

Mr D contacted his GP surgery on 8 June 2016 complaining of lower back pain.

CPN 1 tried to contact Mr D on 13 June 2016. He did not answer.

Mr D attended his GP surgery on 14 June 2016 for a physiotherapy review of his lower back pain. There was no physiological pattern to his pain and he was referred back to his GP.

CPN 1 spoke to Mr D on 20 June 2016. Mr D described a number of incidents involving a wall, the police, junkies and the council. CPN 1 made arrangements to see him on 22 June 2016.

GP 5 saw Mr D on 21 June 2016. Mr D reported that he was experiencing ongoing pain down his right sides and into his right testicle. Mr D was initially given a prescription to treat his pain, but he indicated he might overdose, so GP 2 destroyed the prescription. Mr D missed his appointment at the surgery the next day.

On 21 June the CMHSOP cancelled Mr D's appointment scheduled to take place on 22 June. The reason for cancelling was not recorded in the notes.

GP 2 saw Mr D on 28 June 2016. Mr D was noted to be agitated and experiencing multiple problems including knee, back, hand and testicular pain. Mr D said he was tired and not sleeping well. GP 2 recorded in the notes that Mr D was angry about life, was worried about his grandchildren and grieving the loss of his son. GP 2 wrote in the notes that he would 'chase the CMHT'.

CPN 1 attempted to call Mr D on 8 July and 15 July 2016. They spoke on 20 July and a visit was arranged for 25 July 2016.

CPN 1 undertook a home visit on 26[34] July 2016. Mr D was seen briefly (he said he was going to the dentist) in the presence of a friend, (Friend 1[35]). Mr D spoke of his son who had died the year before. CPN 1 recorded in the notes *"… my feeling was that it was very much bereavement, grief and general counselling that was needed here rather than concerns about his* [Mr D's] *memory"*. Another appointment was made for the following week.

CPN 1 undertook a home visit on 2 August 2016. Friend 1 was present. Mr D talked about a number of issues and agreed to CPN 1's suggestion that he return the following week with Addenbrooke's cognitive assessment paperwork, the results of which he would be able to discuss with Speciality Doctor 2 at his forthcoming appointment.

Mr D was not home when CPN 1 undertook a home visit on 9 August. CPN 1 wrote in the notes that he would try to contact Mr D when he returned from annual leave.

[33] A pain killer
[34] It is unclear why the visit occurred a day later than scheduled. The reason was not recorded in the notes.
[35] It is unclear if this was the friend who called the CMHSOP in March 2016

Mr D's daughter contacted his GP surgery on 11 August 2016 to say she was very concerned about his wellbeing. She said he had turned up at her home in Birmingham previous night. Mr D's daughter advised she had witnessed him take 19 Valium then leave the house that morning. She said she believed her father was heading home and was concerned that he sold his medication to others/used it as capital. She was advised to contact the police.

Mr D was sent a CMHSOP outpatient appointment on 24 August for 20 September 2016. GP 5 wrote to the CMHSOP 25 August to advise that Mr D had made contact to say he was waiting at home for his appointment and that he was unsure what the current plan for him was. He reportedly said he was heading for a 'breakdown'. The team received the letter the next day.

The team tried to call Mr D on 26 August to advise that CPN 1 intended to see him after his annual leave (it is unclear when) with a view to Mr D undertaking an ACE-III assessment. The team was unable to make contact with Mr D.

Mr D telephoned his GP surgery on 1 September 2016. He spoke to GP 5 and said he kept getting dates wrong and could not remember a conversation they'd had the previous week. GP 5 told Mr D the mental health team had previously contacted him and he had an appointment with them on 20 September 2016.

Mr D attended his appointment with Speciality Doctor 2 on 20 September 2016. Speciality Doctor 2 recorded in the notes that Mr D appeared intoxicated and smelt of alcohol; he admitted to drinking four cans of lager prior to attending the clinic. Mr D reported that he was drinking five cans of lager, four days a week, amounting to 40 units a week. Mr D declined to be referred to alcohol treatment services and did not feel he had a problem with alcohol use. Mr D said his GP had restarted him on 50mg Sertraline a day. Mr D did not show any psychotic symptoms and denied any suicidal ideation or intent. Mr D complained of worsening knee pain, which Speciality Doctor 2 advised he should follow-up with his GP.

Speciality Doctor 2 wrote to GP 14 the next day, outlining his assessment of Mr D. He recorded Mr D's diagnosis as:

1. *"Long history of alcohol dependence*
2. *Benzodiazepine dependence*
3. *?* [query] *Cognitive impairment, under investigation"*

Speciality Doctor 2 advised GP 14 that Mr D appeared slightly intoxicated during their appointment, though he was able to engage in conversation. Mr D declined his offer of a referral to alcohol treatment services. Speciality Doctor 2 asked GP 14 to review Mr D in relation to his knee pain, to continue Mr D on his medications, and to consider starting him on B vitamins and Thiamine in view of his regular alcohol use. Speciality Doctor 2 said he would review Mr D in six months.

Mr D telephoned his GP surgery on 30 September 2016 to report he was experiencing dry mouth. He spoke to GP 7 who recommended he attend the surgery for a GP review and blood test.

CPN 1 saw Mr D at home on 4 October 2016. CPN 1 had intended to undertake an ACE-III assessment with Mr D, but Mr D reportedly talked at length and they ran out of time.

Mr D telephoned his GP surgery on 1 November 2016. He spoke to GP 9. Mr D said he was worried about his liver and that his tramadol prescription had recently stopped. Mr D was advised to arrange a blood test.

Mr D was seen by GP 2 on 8 November 2016. Mr D had injured his hand with glass. GP 2 referred Mr D to outpatients and wrote a referral to a hand surgeon.

2017

A friend (Friend 2) of Mr D's contacted the Duty CMHSOP on 5 January 2017. He advised that he had been friends with Mr D for 20 years and acted as an informal carer. He reported he had noticed a deterioration in Mr D and that he had recently found Mr D crying on the floor. He said that Mr D had not been taking his medication and that he admitted he was storing it to take in one go. Friend 2 advised he was now mindful of this and made sure Mr D took his medication. He said that Mr D was not drinking alcohol. The Duty worker tried to speak to Mr D but could not understand him due to poor mobile connection. The Duty Worker told Friend 2 that Speciality Doctor 2 would undertake a home visit on 26 January 2017. He was advised to contact the team if he had any further concerns and was given the out of hours contact number.

An appointment letter was sent to Mr D on 16 January saying he would be seen by Speciality Doctor 2 at home on 26 January 2017.

The Police contacted the CMHSOP on 17 January 2017 to ask if Mr D was known to the team. The WPC reported that Mr D had called the police a number of times and appeared frustrated and experiencing paranoid thoughts. The Duty worker advised he would have to review the information they had on Mr D and confirm what they were able to share with the Police. Mr D missed an appointment with the hand clinic at Kent and Canterbury hospital the same day.

Mr D contacted the admin team on 24 January to say he would not be able to see Speciality Doctor 2 on 26 January. The Duty CMHSOP called Mr D who talked at length about his past and his family. He said people were saying things about him and that someone thought he was a paedophile. The Duty worker wrote in the notes that it was difficult to follow the conversation because of poor mobile reception and that Mr D's speech was at times slurred. Mr D said he was concerned about going out and that he had not received his Diazepam which usually calmed him. He said he was waiting for his GP to call him about his medication. Mr D said he did not think there was any merit in Speciality Doctor 2 undertaking a visit because there was nothing he could help him with however after further discussion Mr D agreed that the appointment should go ahead.

Speciality Doctor 2 was unwell on 26 January and the appointment did not take place. A member of the CMHSOP contacted Mr D the next day to apologise for the missed appointment. He wrote in the notes *"paranoid ideas about people putting stuff on the internet about him sounds like a delusional disorder. Considerable support needs and not taking meds"*. He wrote that Mr D needed an urgent home visit but Friend 1, who was part of the call, said there were no immediate risks to Mr D.

Friend 1 contacted the CMHSOP on 30 January 2017 to say he was concerned about Mr D's welfare. He advised that typically he would check on Mr D daily, but that Mr D had locked the backdoor and was not responding to texts messages or phone calls which was out of character. Friend 1 said that Mr D had been low in mood and stressed for several months, and that he had not left the house for ten days. The Duty Worker advised Friend 1 to contact the Police to request a welfare check. Friend 1 declined to do this, saying Mr D would not like this, and that mental health services were letting Mr D down. The CMHSOP made three attempts to contact Mr D to offer him an urgent appointment but did not get a response. The Duty Worker spoke to the team manager who arranged for Speciality Doctor

2 to undertake an urgent home visit with a member team the same day. The Duty Worker tried to call Friend 1 to tell him but did not get an answer.

Speciality Doctor 2 undertook a home visit with CPN 2 the afternoon of 30 January. Mr D was seen with Friend 1. Mr D reported that a member of the public had called him a paedophile (this was confirmed by Friend 1, therefore not considered a paranoid thought) and the matter had been reported to the Police. Mr D talked at length about past events and was at times difficult to follow. Mr D said he was drinking ten units of alcohol a week. Mr D was conscious, alert and well attired. He said he had not been taking his Sertraline as he was unsure it worked, and that he wished to come off it. He denied suicidal ideation or intent. The plan recorded in the notes was that Mr D would be referred for a psychological assessment and reviewed in four months. Mr D's GP would be asked stop to his Sertraline.

Speciality Doctor 2 wrote to GP 14 (GP) on 30 January 2017. The letter served as Mr D's care plan documentation on 30 January 2017. Speciality Doctor 2 updated Mr D's risk assessment. The entry said: *"Well groomed at interview. No evidence of neglect. He* [Mr D] *denied having suicidal ideations or intent… Nil recent violence or aggression"*. Speciality Doctor 2 recorded Mr D's risk rating as 'medium'.

A multi-disciplinary team meeting (MDT), attended by Speciality Doctor 2 and Consultant Psychiatrist 7, took place on 1 February 2017. The team felt that the complexity of Mr D's needs would be best met by the CMHT. It was recorded in the notes that Mr D's primary difficult was *"anxiety in the context of traumatic/distressing past events, alcohol abuse and poor social functioning. His cognitive impairment appears to be secondary to his anxiety rather than organic in nature. Not appropriate for psychological therapy within the Older People services as no issues typical for older age"*. It was agreed Mr D should be referred to the CMHT and discharged from the CMHSOP.

Speciality Doctor 2 wrote to the CMHT on 1 February 2017 asking that the team take over Mr D's care. Speciality Doctor 2 wrote that Mr D had complex mental health issues which the CMHSOP felt would benefit from therapy. Speciality Doctor 2 wrote that Mr D had a background of alcohol dependence, but was presently drinking within recommended limits. Speciality Doctor 2 wrote that Mr D displayed emotional instability and anxiety, which the team considered to be likely responsible for his cognitive impairment. He advised that neuroimaging and assessment did not indicate that Mr D had a neurodegenerative disorder. The letter was copied to GP 14.

Speciality Doctor 2 called Mr D on 3 February to let him know he was being referred to the CMHT. Mr D said he was happy to engage with the team.

Mr D's referral was discussed at the CMHT MDT screening meeting on 7 February. It was agreed his referral should be discussed with the psychological therapy service.

The CMHT sent GP 14 a completed screening form[36] on 7 February 2017. The referral screening form detailed that the planned outcome for Mr D was *"To be discussed on Friday with Psychology".*

A referral screening meeting took place on 17 February. It was noted that the referral information and request from CMHSOP was unclear given Mr D had been under the CMHSOP since 2015. It was noted that there were inconsistent reports in relation to Mr D's alcohol and benzodiazepam dependence and that he had a previous head injury. The referral was not accepted based on the information provided. "*For further discussion with CMHSOP"* was written in the notes.

[36] A copy of the form was not in Mr D's Trust notes, but was in the GP notes.

CMHT Duty Worker 1 called the CMHSOP the same day to discuss Mr D's case. He was told Speciality Doctor 2 was unavailable and the Duty Worker was busy. CMHT Duty Worker 1 left a message asking that the team contact him to discuss Mr D's referral. The notes suggest that CMHT Duty Worker 1 did then speak to a member of the CMHSOP (role unclear) who said the team felt Mr D's difficulties were best understood in terms of anxiety and that he needed psychological treatment for this. CMHT Duty Worker 1 wrote in the notes *"I explained that following discussion with our psychology service this should be accessed via IAPT provider and GP can consider antidepressant treatment in combination.* [Name redacted] *will feedback to CMHSOP consultant regarding outcome so they can liaise with the GP"*.

The CMHT concluded that Mr D did not have a degenerative organic disorder, rather he had complex mental health issues and a background of alcohol dependence syndrome that would benefit from therapy. Mr D was discharged from the CMHT on 17 February 2017.

The Police contacted Medway and Swale CRHTT on 26 February to ask if Mr D was known to Trust services. The CRHTT advised that Mr D was under the CMHSOP.

Mr D attended the urgent care centre on 6 March 2017 reporting he had been head butted three days before. It was later recorded in his GP notes that he had been noted to be coherent and had normal pupillary reactions. Mr D requested his supply of Diazepam be brought forward, which was rejected. Mr D was given head injury advice.

Mr D failed to attend the fracture clinic on 7 March 2017. He was discharged to his GP.

A friend (the name is redacted in the GP notes) contacted Mr D's GP surgery on 8 March 2017 to say that Mr D was meant to have had a hospital appointment but was found to be carrying weapons – hammers. The friend said he/she was worried about Mr D's mental health. GP 19 advised that Mr D should be encouraged to attend the surgery and the Police should also be informed[37].

The Citizen's Advice Bureau telephoned[38] the CMHSOP Outpatients Psychology service on 10 April 2017 on behalf of Mr D. They explained that there had been some confusion of Mr D's part in relation to arranging a psychological assessment but that he would like to book an appointment. The member of staff advised that she could not discuss Mr D but that she would arrange for a letter to be sent to him.

Assistant Psychologist 2 (CMHSOP) wrote to Mr D on 10 April to advise that he had been discharged from the service on 1 February 2017 and that he should contact his GP for assistance with his needs.

Mr D telephoned his GP surgery on 19 April to report he was experiencing tremors. He was advised to attend the surgery.

Mr D attended his GP surgery on 24 April 2017. He reported that he had collapsed three times in the previous two weeks. Mr D was seen by GP 15 who referred him for assessment. GP 15 advised Mr D to call 999 or attend A&E if he became unwell. Mr D attended hospital the same day with the referral paperwork. He was discharged from hospital the same day.

[37] It is unclear in the notes whom GP 19 was suggesting should contact the police – Mr D's friend or the surgery
[38] The CMHT had sent a fax earlier the same day saying that Mr D had given consent for the Citizen's advice Bureau to discuss his PIP appeal, medical condition and referral to a psychologist.

Mr D attended his GP surgery on 9 May 2017. He was seen by GP 2 who prescribed medication for a cough. GP 2 recorded in the notes that Mr D was angry about malicious rumours that had allegedly been spread about him.

Mr D attended an orthopaedic clinic on 15 May 2017 for review of a historical thumb injury. He was seen by Occupational Therapist 1, who gave Mr D a number of treatment options which he said he wished to think about. They agreed he would be reviewed at the clinic in six months. Occupational Therapist 1 noted in her letter to GP 7 that Mr D was taking Gabapentin[39], Simvastatin, Ventolin, Sertraline, paracetamol, Lansoprazole, Fusiform, Alfuzosin[40], Vitamin B, Thiamine and Montelukast[41].

Mr D assaulted Mr J with a hammer on 18 May 2017. He contacted the Police the next day to report what he had done and say he was concerned for Mr J's welfare. The Police attended Mr J's home where he was found deceased. Mr D was arrested and later charged the same day with Mr J's murder.

Mr D had injuries to his head and hands that he said were caused by hammer blows. Mr D was initially assessed by the Forensic Nurse Practitioner who referred him to A&E for further assessment. The police took him to A&E where he was assessed at 0047hrs on 20 May 2017. Following assessment, Mr D was deemed to be medically fit and discharged to Custody at 0408hrs on 20 May 2017.

Mr D was assessed by clinical staff from the Forensic Service on 20 May 2017. Mr D told the assessing staff that he had always suffered from Obsessive Compulsive Disorder (OCD) and that he had had an awful life. He reported that he had been addicted to Diazepam for a number of years and that he took antidepressants for depression.

The assessing member of staff recorded that Mr D appeared euthymic, had no formal thought disorder or delusional thinking and that he denied any current thoughts of self-harm. Mr D was noted to not display any evidence that he was cognitively impaired and he denied that he was mentally ill. Mr D said that he was unhappy with the community mental health service that he had been offered in 2017 and the previous year and that he had been discharged from the service without being offered an alternative.

[39] Used in the treatment of pain and partial seizures
[40] Used to treat benign prostatic hyperplasia
[41] Used in asthma treatment

6 MR D'S MOST RECENT TREATMENT PLAN

A treatment plan is the approach a Trust takes to care, support and treat a patient. This can take into account numerous factors including mental health symptoms, physical health, social support, family engagement, employment and housing[42]. We have focused on Mr D's care plan, risk assessment and risk management as a means of assessing Mr D's treatment plan.

Care planning

A care plan outlines how a service user's care and support needs will be met. Creating a care plan should be a collaborative process between the service user and the healthcare team (typically overseen by a care coordinator). A care plan should be documented – the service user should be given a copy – and be subject to regular review.

NICE guidance (2011)[43] recommends that the community teams develop care plans jointly with the service user and:

- *"include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependents*
- *Provide support to help the service user realise the plan*
- *Give the service user an up-to-date written copy of the care plan, and agree a suitable time to review it"*

Mr D's care plan was last updated on 30 January 2017 following his review at home with Speciality Doctor 2 and CPN 2. The care plan was written as a letter to GP 14, with the heading *'This letter serves as Care Plan documentation'*. Mr D's ICD 10 Diagnosis was:

"1. Background of alcohol dependence (controlled drinking present)
2. Depressive illness with Cognitive impairment"

Mr D was taking Sertraline 100mg mane[44] but was described as non compliant. He was also taking Simvastatin, Alfuzosin, Lansoprazole, Montelukast and a Ventolin inhaler.

Speciality Doctor 2 (CMHSOP) recorded in the notes that Mr D was conscious and alert during the meeting, and that he engaged well in conversation. Mr D talked extensively about events of the past and was, at times, difficult to follow. He discussed the loss of his son and breakup of his marriage. Speciality Doctor 2 noted Mr D was drinking 10 units of alcohol a week, which fell within the recommended limits. Mr D denied any suicidal ideation or intent.

Mr D's care plan – set out in the letter to GP 14 - was:

1. "[Mr D] *is not keen on taking anti-depressants and I have advised him to discontinue Sertraline. Kindly omit Sertraline from his repeat prescription*
2. *There appears to be psychosocial issues that continue to cause him distress. This includes his childhood trauma, loss of his son a few years ago and martial disharmony leading to divorce. We talked about therapy to address these issues and eventually* [Mr D] *agreed for me to refer him for psychological assessment*

[42] https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/mental-health-assessments/
[43] https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#community-care
[44] In the morning

3. *I will review* [Mr D] *again via a home visit in approximately four months time*[45]*. I will keep you informed of his progress"*

The decision was taken at an MDT on 1 February to discharge Mr D from the CMHSOP and refer him to the CMHT. A letter was sent to Mr D's GP the same day advising of this decision. Mr D was informed by telephone on 3 February.

The Trust investigation noted that Mr D had a complex mental health history and that the CMHT were unaware of this. His care plan did not reflect his mental health history. Mr D's care plan was to stop taking Sertraline, be referred to a psychologist and be seen again by Speciality Doctor 2 in four months. The care plan did not reflect a number of factors pertaining to Mr D including his isolation from his family, his propensity to disengage from services, his anxiety, history of violence/theft and alcohol abuse. The care plan was not written in line with NICE guidelines (e.g. promoting activity) and his crisis plan was not personalised for Mr D, rather he was given generic contact numbers.

Though Mr D had a care plan in place on 30 January 2017 it was redundant in view of the CMHSOP MDT decision taken on 1 February 2017 to refer Mr D to the CMHT (i.e. Speciality Doctor 2 would not be undertaking a home visit to see Mr D in four months).

Mr D was discharged from the CMHSOP and the CMHT did not accept his referral therefore he was no longer under Trust services and did not have a care plan in place at the time of the incident in May 2017.

The Trust investigation set out that staff did not adhere to the Trust transfer policy, therefore we do not revisit it here, though note that CMHSOP staff did not complete a discharge summary for the CMHT in anticipation of the latter accepting Mr D onto their caseload.

Risk assessment and risk management
The Department of Health[46] (2009[47]) describes risk assessment as:

"…working with the service user to help characterise and estimate each of these aspects. Information about the service user's history of violence, or self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that's available, and their more general social contacts could all be relevant. It is also relevant to assess how a service user is feeling, thinking and perceiving others not just how they are behaving."

It defines risk management as:
"… developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include a set of action plans, the allocation of each aspect of the plan to an identified profession and a date for review."

The Trust Clinical Risk Assessment and Management of Service Users Policy (2017) defines risk assessment and management as *"a continuous and dynamic process for judging risk and subsequently making appropriate plans in considering the risks identified".* In the

[45] This would have been in June 2017
[46] https://www.gov.uk/government/publications/assessing-and-managing-risk-in-mental-health-services
[47] This is the most recent Department of Health publication available.

context of the policy, the definition is restricted to the *"assessment and management of the risks of harm to self and risk of harm to others that can be presented by a service user"*. The policy sets out that risk assessment should include:

- a clear statement about the nature of harm
- a summary of risk and related protective factors
- a risk formulation – typically presented as a narrative
- a risk management plan that links directly to risk, protective factors and risk formulation

The policy says risk should be assessed at various times which include routine assessments, assessments following an incident, and changes to the patient's clinical condition or circumstances. Risk assessments should also be undertaken as part of discharge planning or a transfer between clinical teams.

Speciality Doctor 2 saw Mr D during a home visit on 30 January 2017. We have previously detailed under 'care planning' what Speciality Doctor 2 recorded in the progress notes about Mr D's presentation (e.g. he discussed the death of his son and break up with his wife).

Speciality Doctor 2 updated Mr D's risk assessment on 30 January 2017. He recorded that Mr D was well groomed, showed no sign of neglect and denied any suicidal ideation or intention. Mr D was noted to have no recent incidents of violence or aggression and that his risk rating was 'medium'. The Trust internal investigation noted in its tabular chronology that Mr D's risk factors were not explored fully because focus was on Mr D's presentation and needs.

The risk assessment on 30 January 2017 did not provide a narrative of Mr D's risk formulation, nor detail a summary of Mr D's risk (e.g. historical violence) and protective factors. There was no risk management plan linked to the risk assessment.

Treatment plan

There is evidence of the CMHSOP staff having multiple contacts – by phone and in person - with Mr D from May 2015 onwards (the time of his last referral into the team). They responded promptly to his (or that of his GP and/or friends') phone calls for assistance and undertook home visits. For example, the team undertook a home visit on 30 January 2017 in response to a concerned friend's phone calls to the team earlier in the day and on 27 January 2017.

Mr D would sometimes disengage from Trust services and there is evidence that the team continued to try to contact him during these times.

Despite these multiple contacts with Mr D, there was an absence of meaningful assessment or formulation of his mental health issues by the CMHSOP. He was seen by numerous members of staff, but there is little sense anyone was centrally managing his care, despite being under the team for nearly two years.

His care plan and risk assessment were limited in scope and we could not find evidence of a risk management plan or a personalised crisis plan. The CMHSOP did not complete a transfer/discharge summary for Mr D when it referred him to the CMHT, which would have contained a clear plan for the receiving team to refer to.

Mr D had not been formally assessed therefore his care was not defined, however the CMHSOP had enough information to formulate a plan of care, which even if he refused to accept, should have been offered to Mr D and communicated to the CMHT.

There is no evidence of the CMHSOP setting out a treatment plan for Mr D, or ongoing evaluation of his care, as would be expected under Trust and national policy.

7 THE TRUST INTERNAL INVESTIGATION

NHS England's Serious Incident Framework (2015[48]) defines a serious incident as:
"… events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

… The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these."

The framework gives examples of serious incidents, which include unexpected or avoidable deaths, unexpected or avoidable injury that has resulted in serious harm, actual or alleged abuse (e.g. sexual, physical and psychological). In addition, never events, and incidents that threaten or prevent the organisation from delivering services also qualify as serious incidents.

NHSE says serious incidents should be reported within two working days of being identified. The guidance identifies seven key principles for managing all serious incidents:

1. *Open and transparent*
2. *Preventative*
3. *Objective*
4. *Timely and responsive*
5. *Systems based*
6. *Proportionate*
7. *Collaborative*

It recommends that investigations be conducted using a systems-based investigation (i.e. Root Cause Analysis) methodology that sets out:

- *"The problems (the what?);*
- *The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and*
- *The fundamental issues/root cause (the why?) that need to be addressed."*

The framework details the stages to the investigation process which include 'gathering and mapping information' and 'analysing information'. Examples of the former include interviewing staff, reviewing notes and mapping services. Examples of the latter include considering the fundamental issues and root causes to be addressed – this extends to mapping against best practice.

The framework advises that the investigation team have a lead investigator with appropriate accountability at manager/director or Chief Executive level. The team should be knowledgeable of the investigation process and have the appropriate skills and competencies to complete the investigation.

The framework highlights the importance of involving patients, victims, their families and/or carers in investigations:

"involvement begins with a genuine apology. The principles of honesty, openness and transparency must be applied. All staff involved in liaising with and supporting bereaved and

[48] https://www.england.nhs.uk/wp-content/.../2015/04/serious-incidnt-framwrk-upd.pdf

distressed people must have the necessary skills, expertise and knowledge of the incident in order to explain what went wrong promptly, fully and compassionately…
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."

The framework sets out the stages in which patient, victims, families should be involved in an investigation or kept informed of its progress. These include having an opportunity to ask questions and raise concerns, comment on the terms of reference, be given access to the investigation findings and given an opportunity to comment on the findings and recommendations.

Trust policy
The Trust 'Investigation of serious incidents, incidents, complaints and claims policy' (January, 2017) says that the investigating team can include a local manager/senior manager from the service in question, and should be supported by other clinical and non clinical staff. Members of the investigating team must have received RCA training. The policy defines the key features of a good investigation as:

"a) Clear terms of reference/parameters
b) A thorough identification and analysis of events
c) A clear and concise report
d) Clear rationales for decisions/actions taken
e) A robust audit trail of actions taken."

The policy details the process for root cause analysis, including what information/evidence to consider/source, the use of interviews and statements, and how to map events (e.g. a timeline). The policy also sets out approaches to analysing evidence including the use of Fishbone diagrams, barrier analysis, change analysis and the use of Five Whys.

The policy references Duty of Candour and that service users and relatives should be informed at the earliest opportunity of investigative work.

Investigation reports should be submitted to the Care Group Serious Incident Lead within 45 working days, and to the CCG within 60 working days.

The Trust wide Patient Safety and Mortality Review Group, chaired by the Trust Medical Director, review the incident reports, which in turn are signed off by the Quality Committee.

Serious incident process for the Community Recovery Care Group (CRCG)
The Trust has a flow chart detailing the progression of an SI from it being reported as an incident on Datix, through to action plan sign off. The flowchart says the completed RCA and action plan should be submitted to the Patient Safety and Risk Manager on day 30. Quality checks are carried out by the Patient Safety and Risk Manager, Head of Patient Safety, CRCG Heads of Service and Director of Nursing and Governance. The completed SI report and action plan must be submitted to the CCG by day 60, and a copy of the report shared with the patient/family.

Service Managers receive the RCA report and review the recommendations made by the investigators. They are required to write the resultant actions prior to the Trust signing off the RCA. The CRCG Patient Safety Team is responsible for allocating ownership of any actions and logging this on Datix. The owner of the action must complete the action within the agreed time and upload evidence to Datix. The CRCG weekly Incident Review panel reviews completed actions and underpinning evidence to ensure it is robust. In instances where sign off cannot be given, the action is reopened. Any action plans that breach their

completion date are escalated to the Head of Service as part of the monthly Care Group SI meeting.

The Trust investigation
The Trust investigation was undertaken by:

- Patient Safety and Risk manager, Community Recovery Service Line
- Deputy Medical Director/Consultant Psychiatrist
- Consultant Psychologist, Lead for Psychological Practice for East Kent, Community and Recovery Service Line and Clinical Lead for Open Dialogue

All of the investigation team had received RCA training, in line with Trust policy. The report was completed on 21 July 2017.

The report was signed off by:

- Interim Director, Community Recovery Care Group, 29 September 2017
- Patient Safety Manager, 3 October 2017
- Executive Director of Nursing and Quality (on behalf of the Trust-wide Patient Safety Group), 11 October 2017

The report was shared across the Trust, including with Canterbury CMHT and CMHSOP.

The report is divided into a series of subsections:

- Introduction to the service user
- Incident description and consequences
- Terms of reference
- Involvement and support of key people
- Findings
- Contributory factors
- Root causes
- Conclusion

The report provides a succinct account of the service delivery problems identified during the investigation. It sets out the relevant Trust policy (Transfer and Discharge policy) and identifies the gaps in practice and the failure of staff to adhere to the Trust policy. Staff were interviewed from the CMHT (individually) and CMHSOP (as a group) and Mr D's GP was seen as part of the investigation.

However there are areas in which we consider that the report could have been strengthened. These primarily relate to providing more information and testing assertions. For example:

- The report provides little information about Mr D's engagement with Trust services prior to his discharge in February 2017, despite evidence that he was in contact.
- The report says "*CMHSOP have confirmed that they have a robust transfer process for services users between internal teams that mirrors the policy".* The report does not set out what the process is, nor whether it independently confirmed that the CMHSOP transfer policy is robust.
- The report describes *'ineffective communication'* between teams but does not expand on this point, or why staff failed to adhere to the Trust transfer policy.
- It notes that discussions between the teams were not recorded and it is not clear which staff were informed Mr D's referral to the CMHT had been declined; the report

does not set out detail of Trust record keeping policy and what would be expected of Trust staff.

- Leading from this, the report says *"The service user was then discharged from Canterbury and Coastal CMHT (February 2017) following team discussion about the referral from CMHSOP and* ***liaison*** [our emphasis] *between the teams on 17/02/17"*. The report does not describe this liaison, nor explore why, if the two teams had liaised in relation to Mr D's referral/discharge, the CMHSOP did not put a plan in place for Mr D and confirm this in writing to him and his GP. The report says staff did not follow Trust policy, but does not set out if it considered the underlying causes of this e.g. staffing or caseload.
- The Police and Citizen's Advice Bureau both contacted the Trust in February and April 2017, respectively, but the report does not explore whether the Trust response on either occasion was appropriate. For example the Citizen's Advice Bureau faxed the CMHSOP Mr D's consent to discuss his case, but they were told the Trust could not share information about him with them. The report does not set out whether this was in line with Trust policy and whether any additional steps should have been taken in response to this contact.
- The report makes reference to Mr D's forensic history but says no further detail was available. There is no evidence the investigators sought to contact the Police or probationary service about this.

Did the Trust internal report answer its terms of reference?
We set out below the Trust investigation terms of reference and our assessment of whether these were met

Terms of reference	*Mazars comment*
Examine the care and treatment provided, including adequacy of: • Risk assessment and management plan • Comprehensive assessment of their health and social care needs. • Care plan • Medication • Use of best practice	The report says "*Investigators consider that whilst under the care of CMHSOP the team carried out a prolonged assessment of the service users* [sic] *health and social care needs to ensure that they offered an appropriate plan of care to meet these. Review suggests that the complexities were recognized by the team and appropriately managed at this point"* The report does not set out how it reached these conclusions and how it benchmarked practice. The Community recovery Care Group Patient Safety and Risk Manager, who was a member of the investigation team (when she was a Patient Safety Manager) told us the team had considered a number of factors pertaining to Mr D's care and treatment (e.g. Mr D's disengagement), and that these had been compared against expected Trust policy/protocol and reported by exception i.e. in instances where no concerns were identified this was not set out in the report. The report does not reference/apply Trust or national policy in relation to Mr D's care. The report says the Trust implemented a new Risk Assessment document since the incident, but does explore Mr D's risk in any depth (it notes that Mr D had been involved with the police in the past, had been in prison, and had engaged in fights but says no further detail was available). Therefore it is unclear why the new

	assessment document was specifically referenced. The Trust investigation tabular timeline contains the comment that Mr D's risk assessment on 30 January 2017 did not explore his risk factors fully because focus was on his current presentation and needs; it is not detailed how the investigators reached this conclusion (e.g. did Speciality Doctor 2 tell them?). The report does not provide a comprehensive overview of the care and treatment provided to Mr D. In particular the investigation makes no specific reference to his care plan updated 30 January 2017, medication and alleged substance misuse/alcohol misuse.
Review compliance with Trust policies and procedures specifically, Transfer & Discharge of Care of Service Users, Did Not Attend policy.	The report does review compliance with the Transfer and Discharge of Care of Service Users policy, and, the CMHT Operational policy. The report lists the Trust CPA policy as referenced within the investigation, but makes no further reference to it in the report. It does not consider the application of the Did Not Attend policy. It may have been helpful to the investigation if a number of other Trust policies had been considered that include Dual Diagnosis, Disengagement, Risk Assessment and Management, and Record Keeping and Management.
Review the robustness of the CMHT and CMHSOP system and process for: • Assessing new referrals to the team • Management of treatment and transfer between services.	The report does not describe the referral process or set out how new referrals to the CMHSOP or CMHT are assessed. The report says "*CMHSOP have confirmed that they have a robust transfer process"*. There is no evidence that this was tested by the investigators. There is no reference to the CMHT transfer processes; the report sets out the CMHT policy if a referral is rejected, not if transferred.
Review the status of immediate mitigating actions identified and implemented following the 72 hour report	The report says *"Investigators can confirm that actions and recommendations identified in the 72 hour report have been completed or incorporated into this full Learning Review."* The report does not set out the relevant detail of the 72 hour report. The report says that a Reflective Practice session with the CMHSOP took place and that the Trust launched a new Risk Assessment document in July 2017. The report does not say if the above were identified by the 72 hour report, and whether any additional actions or recommendations have been incorporated into the full Learning Review.
Provide a chronology of events leading up to the incident	The report says *"Detailed chronology has been completed going back just under one year prior to the incident, which covers the majority of involvement with the teams; 13/06/2016 to date of interview with mental health one day after the incident* [on] *20/05/2017…. Investigators have*

	reviewed and considered any other contacts prior to these dates" We were told that the investigators took into account Mr D's whole mental health history and that one of the team had met with Mr D's GP to gain a broader understanding of his medical history, though the detail was not reflected in the report. We were told that the Incident Review and RCA Learning Review allocation process set the scope/timeframe for the review. A detailed chronology is not in the main body of the investigation report but the Trust did provide a separate tabular chronology – a record of all the entries to Mr D's notes during the specified period - which was compiled as part of the investigative process. It is referenced at the end of the Trust report, for which the reader is instructed to '*please see separate document*'. An anonymised version of the tabular chronology was submitted to the CCG with the final report[49]. The report notes the CMHSOP referral in February 2017 described *'complex mental health issues, a background of alcohol dependence syndrome and that therapy would benefit him'.* The main body of the Trust report does not provide detail of Mr D's referenced complex mental health issues or history of alcohol dependence. The report says: *"The most recent referral into Secondary Mental Health services was May 2015 for a review and opinion regarding memory difficulties. The service user remained under the care of the CMHSOP from this date until they discharged in early 2017. The service user's GP advises that he was seen repeatedly by Mental Health services over the previous 20 years"* This simplifies Mr D's engagement with mental health, particularly Trust services. We note the scope of the Trust investigation timeframe (13 June 2016 – 20 May 2017) but consider there should have been more detail within the report about Mr D's engagement during this period. For example, Mr D attended an appointment on 20 September 2016 with Speciality Doctor 2 during which Speciality Doctor 2 considered him to be intoxicated. The tabular timelines of Mr D's notes contains the entry Speciality Doctor 2 made in the notes about this appointment, but the Trust investigation report makes no comment. The tabular chronology does set out comment against some of the medical entries (e.g. Mr D's risk assessment on 30 January 2017). The main body of the report would have benefitted from this comment and assessment.

[49] The Trust SI report template has changed since the investigation into Mr D's care and treatment. A tabular chronology is now included at the end of the main SI report.

	The main report does not describe (within the specified timeframe) the nature of Mr D's engagement with staff, his presentations, history of substance misuse, failure to attend appointments and episodes of crisis. There is no reference to contacts made by the Police to the Trust on 26 February 2017 and the Citizen's Advice Bureau on 10 April 2017. We note there is a tabular chronology of Mr D's medical records during the investigation timeframe, however we did not initially receive this with the Trust report and it is not clearly signposted in the report. It is not obvious to the reader that there is an underpinning chronology. The summary paragraph set out in the main report provides the reader with little insight into Mr D's chronology of care, his mental health, and his care and treatment.
Identify care and service delivery issues along with the factors that might have contributed to them	The report does identify care and service delivery issues (e.g. non compliance with Transfer policy and ineffective communication between teams) but not necessarily the factors that contributed to them. The underpinning 'why' aspect of the investigation, as set out in the Trust SI policy, is not explored. For example, it is unclear why staff did not adhere to the Transfer policy.
Identify underlying root causes and key learning from this incident to reduce the likelihood of recurrence	No root causes were identified – which can often be the case in investigations. The recommendations set out in the report should serve to ensure that staff adhere to the Trust transfer policy; however it is only through monitoring and assessment (e.g. audit) that the effectiveness of these changes will be known.
Provide a report with clear learning, recommendations for the Trust.	The report sets out that staff failed to adhere to the Trust transfer policy. It also provides recommendations in response to this.

Was the investigation completed in a timely manner?
The Trust report was completed and dated (21 July 2017) within the 60 days set by the NHSE SI framework. It was signed off on 11 October 2017, ahead of the required submission date of 19 October 2017.

Were all root causes and potential lessons identified, actioned and shared?
The report did not identify any root causes, which can often be the case in investigations. However we consider there are areas in which more information/detail should have been provided and/or explored. We were told that the investigators did consider a variety of factors, but the detail is not reflected in the report. As a result, we consider it a missed opportunity to identify further potential learning, for example managing complex clients who repeatedly disengage.

Were the recommendations appropriate, comprehensive and flow from lessons learnt and root causes?

We consider the recommendations to be appropriate based on the report findings, though as set out above, note that there are additional areas the investigation could have explored, which in turn may have resulted in further recommendations.

Does the action plan reflect identified contributory factors, root causes and recommendations?
The Trust investigation places emphasis on the lack of adherence to the Trust transfer policy which we agree was a primary factor in this case. We consider that the action plan reflects the investigations' learning on this basis. However we note the restricted scope of the investigation and it is possible further factors may have been identified if the investigation had explored further areas such as Mr D's risk, medication, care plans, alcohol use and disengagement. Again, we note we were told investigators did consider these factors, but it is not detailed, and we consider further review was warranted.

Are the actions comprehensive?
The actions adequately address the recommendations/learning, subject to the monitoring and audits taking place.

Were the Trust Clinical Governance processes in managing the RCA appropriate and robust?
The Trust has a 'STEIS Referral/RCA Submission Process' which is a flowchart that details the steps to be undertaken if the Mortality Panel decided if the incident should be reported to STEIS. An SI must be reported within 48 hours of the decision. SI reports must be submitted within 45 days for first line quality checking and Director Approval. The Patient Safety Manager must then undertake a second quality check at which point the report should be submitted to the Executive Director of Nursing for approval. If the Patient Safety Manager or Director of Nursing have questions about the report it should be returned to the investigation leads at that point. The final anonymised report should be approved and submitted to the CCG within 60 days.

The Trust SI policy says the Trust Wide Patient Safety and Mortality Review Group, chaired by the Trust Medical Director, reviews all Trust investigations and is responsible for ensuring there is adequate evidence to demonstrate learning and to monitor/support local groups to implement action plans. The Trust Wide Patient Safety and Mortality Review Group reports to the Quality Committee. The Quality Committee is responsible for reviewing incident reports on behalf of the Trust Board.

The Patient Safety and Mortality Review Group is responsible for ensuring any resultant actions are shared with the relevant service, and for monitoring the Trust's progress with its action plan. This Group reports to the Quality Committee which in turn reports to the Trust Board.

We asked the Trust to provide us with evidence of any internal review of the investigation report and sign off by the Quality Committee, and Trust Wide Patient Safety and Mortality Review Group. The Trust told us that in practice, the agendas and memberships of both meetings did not support the RCA review process, and that incidents/RCA reports were not reviewed by either group. We were told that the Quality Committee receives updates on investigations and were given examples of papers being submitted to the Quality Committee in March and November 2018 which provided detail of the learning from the SI. We were also given a paper submitted in June 2018 which provided an update on the SI action plan. We were told that SIs are approved via the STEIS Referral/RCA Submission process as set out above. We were told that the Trust is reviewing its SI policy to reflect this revised approach. Going forward, the Head of Patient Safety or Deputy Director of Quality and Safety will independently check reports for evidence and assurance.

The RCA report was signed off by the interim Director (Community Recovery Care Group), Patient Safety Manager and Executive Director of Nursing and Quality as per the Trust STEIS process and CRCG SI process.

The focus of the investigation was the failure of staff to adhere to the Trust transfer policy. This was a fundamental factor in Mr D's case but the Trust report lacks detail of any analysis undertaken. We understand the Trust investigators did consider Mr D's history beyond the scope of the investigation, and met with his GP as part of this process, but this detail is not reflected in the report. The investigation report did not set out the detail of any consideration of Mr D's risk, medication, care plans, disengagement or alcohol dependence. Trust investigators were satisfied that Mr D was appropriately managed by the CMHSOP, but gave no indication in the report of how this assessment was reached, whether practice was in line with Trust or national policy and whether issues such as Mr D's repeated disengagement and periods of substance/alcohol abuse had been comprehensively explored; all of which could have contributed to further learning. It is our understanding that Trust investigators did consider Mr D's care in the context of Trust policy and protocols, but this is not evidenced.

The Trust investigation was conducted in line with NHSE and Trust SI policy – though of limited scope - and signed off in line with Trust STEIS and CRCG SI process. However the SI was not signed off in line with the Trust policy. The report was not reviewed by the Trust-wide Patient Safety and Mortality Review Group, the aforementioned Manager and Directors signed off the report on an individual basis, as opposed to the report being subject to a broader quality assurance process.

Recommendation 1: Trust SI reports should set out the evidence and analysis used to form judgements as to whether practice was undertaken in line with Trust policy.

Recommendation 2: The Trust should enforce its assurance and sign off process/policy for serious incident reports

8 THE TRUST'S PROGRESS WITH ITS ACTION PLAN

We set out below our review of the Trust's progress with its internal investigation action plan.

1. General Observations

- The action plan does not provide a section for responsible individuals and Executive team member to sign-off once complete. It is not possible to confirm in some cases whether individual actions on the action plan have been signed off by those allocated responsibility. This should be added to the document to ensure appropriate governance.
- The action plan indicates that the person responsible for completing the action plan (the CRCG Patient Safety and Risk Manager) is also responsible for monitoring and review of the action plan. Governance over the action plan could be significantly improved by segregation of these roles. We would normally expect an Executive team member to have oversight of the action plan.
- The names of those signing off the overall action plan are not stated. We recommend that for clarity, the positions and names of individuals signing off key assurance documents are stated.
- Individual actions are not signed off in a consistent manner, for example, some actions refer to sign off by the stated responsible individual, whereas some refer to an individual who is not responsible for that particular action. In some cases, reference is made to sign-off by a governance group.
- The cover page states that the draft action plan was completed on 4 August 2017 and the action plan finalised on 29 September 2018. This is a lengthy time period for finalisation of the action plan (over a year) and should be investigated further. There may be an error in the date stated or the September 2018 date may refer to the last time the document was updated. In the case of the latter, this should be amended on the form for clarity.
- In some areas greater precision and consistency is required in the wording of actions required to provide greater clarity and assurance that specific recommendations are being captured in the actions implemented. For example, actions i. and ii. are essentially duplicates in terms of what they are seeking to achieve.
- Acronyms should be explained, for example it is not clear what CRCG and OASL refers to on the cover page and how these teams relate to those involved in the incident. It is important from a governance perspective that the teams involved in the action plan are clear to all involved in its oversight.
- The Trust has missed action deadlines in several instances as our review indicates that although actions are recorded as complete, evidence is missing to support this assessment, particularly around the need for audit of compliance with new procedures.
- Low attendance is noted at some meetings where information and actions have been shared relating to this serious incident. It is important that the Trust verifies that communication is comprehensive and consistent to all members of staff concerned.

Our review of the Trust action plan identified some areas where we consider greater clarity would strengthen the Trust's assurance processes.

Recommendation 3: The Trust should review its action plan process to strengthen action sign off, specifically:

- **A section in the action plan template to assign individual and/or executive team responsibility for signing off actions**
- **Details of executive team oversight**
- **The names and roles of individuals responsible for signing off actions**

We have highlighted for the Trust in the table below additional evidence which would be helpful to provide comprehensive assurance that the actions resulting from the investigation's recommendations have been implemented or there are clear plans to do so.

2. Summary of Action Plan Progress

Actions *(in italics)*	**Key Observations**	**Outstanding Evidence**	**Mazars view**
Recommendation 1. CMHSOP to ensure that all requests for a team to take over the care of a service user must follow the Transfer & Discharge of Care of Service Users policy			
i. Service Manager of the CMHSOP to ensure that all Professionals in the team are aware of and follow the Transfer & Discharge of Care of Service Users Policy. **Responsibility:** **Service Manager – Ashford, Canterbury & Thanet CMHSOP** **Target Date for Completion:** **30/9/17**	• The evidence provided to demonstrate raising awareness of the Transfer & Discharge of Care of Service Users Policy consists of reference to the issue at the Quality & Performance meeting for the Older Adult Care Group of 14/9/18. • This is relatively weak evidence as the reference in the minutes is brief and an action to summarise the transfer policy is referred to the next meeting. In addition, this meeting was poorly attended (12 apologies out of 21 planned attendees). An action was attributed to the Service Manager, to be picked up at the next meeting. • We asked to see the minutes of the following meeting to follow up on this action, but these were not provided. It is not	• Minutes of Quality & Performance meeting held **after** the meeting on 14/9/18 • Copies of responses from **all** service managers that the policy has been shared. • Evidence of actions taken to ensure policy is **followed**, for example audit.	**AMBER/GREEN**

	therefore clear how the evidence provided relates to the specific action required of the Service Manager. • Clarification is required as to whether it is the Service Manager to whom the action is assigned who chaired the meeting. • There is no reference to actions taken by the Service Manager to ensure all professionals in the team **follow** the policy. However, this is mitigated somewhat by evidence of revised operating procedures in action ii which essentially repeats action i. • An email sent by the Assistant Director of CMHSOP on 7/8/17 to all Older People's Service Managers asked for the Policy to be shared with teams and for a confirmation by 28/9/17 that this had happened. The copy of the email provided was sent in a Word document and it is unclear if the policy was attached. There is no evidence of confirmation from the Service Managers that the policy was shared. • This action is marked as complete as at 14/9/17 (the date of the Quality and Performance Meeting), however as indicated above, more evidence was required at the time that this action was complete in terms of ensuring all professionals in the team are aware of **and** followed the discharge policy, for example audit follow-up (see action ii below). • The action is marked as signed off by the Patient Safety and Risk Manager, however this is not the individual responsible. • We were told that there were no minutes available detailing the action sign off, but the action had been closed on the Datix system. • The Trust Transfer and Discharge of Care of Service Users policy (including 7 day follow-up) was updated and implemented in December 2018.		

ii. Assistant Director CMHSOP to ensure that all CMHSOPs are aware of and following the above Policy. **Responsibility:** **Assistant Director – CMHSOP** **Target Date for Completion:** **30/9/17**	• For the most part, this action appears to duplicate action i. but assigns responsibility to the Assistant Director. From a governance perspective, responsibility for an action should be assigned to a single individual to avoid misunderstanding. • An email sent by the Assistant Director of CMHSOP on 7/8/17 to all Service Managers asked for this Policy to be shared with teams and for a confirmation response to this effect by 28/9/17. It is unclear whether the policy document was attached (the version of the email we received was provided in Word, not its original format). • An email response from the Team Leader/Occupational Therapist, Swale CMHSOP, dated 10/8/17 responds as requested to the Assistant Director's email. There are no further copies of emails from other teams in the service to confirm that the policy had been shared. • The policy is dated March 2015 and was due for review in March 2018. We were advised that the policy has not been updated. • Evidence indicates that the policy has been shared with teams through the Assistant Director and Service Managers attending the Super-Locality Meeting (held 24/8/17), however attendance at this meeting was poor (8 out of 20 attendees present). • Further evidence is required to complete this action in terms of providing assurance that all teams are aware of **and** following the policy, for example audit follow-up. • The action is marked as signed off by the Patient Safety and Risk Manager however this is not the individual responsible.	• Confirmation that the policy document was attached to the email sent by the Assistant Director of 7/8/17 (the Word version of the email we have does not evidence this). • Copies of responses from **all** service managers that the policy has been shared. • Evidence of actions taken to ensure policy is **followed**, for example audit.	**AMBER/GREEN**
iii. OPMH Care Group's Patient Safety & Risk Manager to complete an audit of transfers in 6	• Evidence indicates that an audit has been carried out by the Patient Safety and Risk Manager (an email was sent on 19 April 2018). The timing is unclear on the documents provided but the Trust advised it was completed on 19 April 2018. We	• Evidence of sharing a summary of the audit results with the OPMH Health & Safety Directorate Team Meeting – and	**AMBER/GREEN**

months' time between CMHSOP & CMHT and share results in the OPMH Health & Safety Directorate Team Meeting **Responsibility: OPMH Care Group Patient Safety & Risk Manager** **Target Date for Completion: 31/3/18**	were told the scope of the audit was all clients transferred from CMHSOP to CMHT, and closed CMHSOP referrals where within two months there was a referral starting with a CMHT. The timeframe for the audit was six months. The audit was designed to examine the team transferred to and from, completion of risk assessment, updated needs assessment and care plans, update progress notes, any 117 data, any advance decisions, evidence of agreement to transfer in writing, and a response to this within four weeks, plus what information was shared with the service user. • The recording of the audit results could be significantly improved, for example an accompanying report to summarise findings. • The audit is recorded in a document called "OACG transfer audit" which detailed the above audit, though is not dated and there is no explanatory cover note to explain the purpose, scope and contents of this document. The audit results detail 23 cases. • The document in isolation is unclear, the quality is poor in terms of labelling, and the majority of fields are not completed. It indicates that for the one case examined transfer of care is not appropriately documented. A significant number of entries (16 out of 23) are noted as inappropriate referrals rather than transfers. • The Patient Safety and Risk Manager, sent an email on 19/4/18 (at 1331hrs) called 'SPOA refs OACG action'. The email refers to the audit and the issue of inappropriate referrals to CMHSOP. It requests that this is considered for future planning for the Single Point of Access. The email is addressed to the interim Assistant Medical Director (CRCG), Business and Service Development Lead, and interim SPoA Clinical Leader • The Patient Safety and Risk Manager, sent a further email on 19/4/18 (at 1401hrs) called 'Transfers between teams to	individual team meetings (as requested by the Patient Safety and Risk Manager on 19/4/18). • Evidence of recipients of both emails sent on 19/4/18 sharing learning and consideration of the serious incident. • Confirmation of the roles of the two recipients of the email called 'Transfers between teams to OACG' on 19/4/18.	

	OACG' to two members of staff, and copied three individuals. The roles of these individuals is unclear. The email refers to the audit and reiterated the message to communicate learning to their teams and requests evidence of this. • There is no evidence provided of the audit results being shared in the OPMH Health and Safety Directorate Team meeting. • The action is marked as closed by the responsible individual, however as indicated, some additional evidence is required to confirm completion.		
Recommendation 2: If a service user has been told that he will be transferred to another team and the decision is then made not to work with them, this decision must be shared with the patient, referrer and GP. Any recommendations for alternative treatment or support should also be shared			
i. An audit will be carried out to ensure that the process is consistently being actioned **Responsibility:** CMHT Service manager /operational team leader **Target Date for Completion:** end November 2017	• The action to implement this recommendation specifically refers to audit of compliance with process. • Various new procedures have been introduced to improve procedures and communication of decisions. Evidence is provided in a document called "A Day in the Life of a Community Mental Health Team", A Guide, dated March 2018. This includes standard letters to ensure consistency in communication and describes CMHT meeting arrangements. This is a clear and useful document. We were told that the document is on the Trust intranet and available to all staff. • Further evidence of the revised processes is provided in the Community Mental Health Teams Operational Policy, version 4 dated April 2018. This document has specific sections on transfers of care, discharges and communication with GPs. It references the daily screening of referrals. • It should be noted that the tracking record in this policy needs to be updated to reflect the changes made between versions 2 and 4. We were told that the policy had been reviewed and updated to take into account learning from incidents and when further improvement was required.		**GREEN**

	• The Trust provided details of a Clinical Quality Check (CLiQ) audit completed by the Clinical Quality Manager for the CRCG (East Kent) on 29/10/18. 101 case notes were reviewed, looking at a variety of clinical standards including care plans, risk assessments, progress notes, supervision, sick leave, DNA, RiO Screening and 28 Day Breach letters. Of the 101 cases, 70% met the required standards; 30% required interventions to improve. The next CLiQ check was scheduled for 29 November 2018. • The Clinical Quality Manager emailed the audit results to the CMHT Service Managers on 29 October 2018. She indicated she would review the priority areas identified in the October check, a sample of risk assessments and a selection of new cases. A CLiQ CRCG Action Plan dated 29 October 2018 was attached to the email. The CMHT Service Managers are the leads for the action plan. • The action is not signed off by the responsible individual but the action plan was closed at the CRCG SI Review Panel on 25/7/18. We note that the Datix number does not match those of the Mr D Trust investigation report (WEB 20311), but the Trust has confirmed the action was closed at this meeting under Datix number 68105. • Sign-off of the action should be provided by the responsible individual and be applied consistently throughout the action plan document.		
Recommendation 3: Community Recovery Care Group (CRCG) should review the use of the RIO Screening form, its purpose and the minimum quality standards expected when completing			
i. Quality standards for completion of the screening form to be taken forward by the Service lines Quality Lead. Monitored by way of an audit.	• Monthly quality (CLiQ) checks are completed by a Quality Lead in each CMHT. One area reviewed is the screening form	• Clarification of the applied quality requirements used in Clinical Quality Checklist • Audit of RAG rating system	**AMBER/GREEN**

These standards can then be shared and monitored by way of an audit. **Responsibility:** CRCG Quality Lead **Target Date for Completion:** end November 2017	• An example completed Clinical Quality Checklist is provided for January 2018 as evidence of the monthly quality checks on the screening form. • The form is a pass/fail against two criteria: *Is the screening tool being completed? Quality of completion.* There is no guidance to accompany the form to define the quality requirements (though we assume Trust policy is the benchmark). • There is no commentary in the Detail column on the form other than for one case to say screening was not completed without any reason stated for this. From the evidence from this one example, there is no detail provided which can be shared for monitoring and sharing purposes. • The Trust provided a document called Process for RAG Rating which defines the RAG ratings to be applied on the referral screening form to manage/prioritise referrals. • It is not clear if this has been implemented as a standard operating procedure as it is not a dated or approved document but we were told by the Patient Safety and Risk Manager it has been used within the Care Group since 29/9/17. • The document refers to an action agreed by the Community Patient Flow Board on 14/8/17 to RAG rate all referrals. It is not clear how this Board links into the Trust's governance framework. • We were told that the RAG rating system has not been audited, but CLiQ checks do review if the RAG status is used within daily CMHT Red Board meetings. • The action is marked as signed off by the Patient Safety and Risk Manager. This person is not the responsible individual for this action.		

	• Sign-off also refers to "MDT ….governance system" – we were told this means the CRCG incident review panel terms of reference and SI process document		
Recommendation 4: GPs must be informed in writing when a referral is screened and not accepted into the CMHT			
i. Audit to be carried out within the CMHT to ensure that GPs are being informed of decisions not to accept service users into their care as per CMHT Operational Policy **Responsibility:** CMHT service Manager/Operational Team Lead **Target Date for Completion:** End Nov 2017	• The Trust references existing evidence provided in Recommendation 2 for this action. This provides the guidance document "A Day in the Life of a Community Mental Health Team" which contains the relevant standard letter **- Letter 6. Referral not accepted – signposting.** • The template is addressed to "Dr/Referrer". The Trust needs to ensure when the referrer is not a GP that the letter is also copied to the patient's GP. • The Trust provided an example of the Canterbury and Coastal CMHT weekly compliance report. It looks at whether the following have been completed: core assessment, crisis plan, care plan, risk assessment, and compliance. The audits were undertaken the weeks ending 13/4/18, 11/5/18, 29/6/18 and 20/7/18 (the action was scheduled for completion in November 2017). We were told that any gaps in compliance would be picked up by the Service Manager. The Trust provided the audit as evidence that communication with GPs were being informed of decision, but there is no reference to such a measure in the audit report. GPs are not referenced however we understand this is because the reporting is by exception only. We were told any gaps in non compliance would be addressed by the Service Manager. • Minutes of the CRCG Incident Review Panel, 25/7/18 indicate that the action has been closed. The Datix number does not match that of the report, but the Trust has confirmed it relates to the actions in question. • The action is not signed off by the responsible individual.	• Trust to confirm Canterbury and Coastal audit results are by exception which is why GPs are not referenced. • Evidence an audit was undertaken prior to the action being closed in November 2017	**AMBER/GREEN**

	• We reviewed a small sample of GP letters in relation to this point. Please see below for more detail		

The Trust provided a significant amount of evidence detailing its progress with its action plan. On balance, we consider that the actions are complete but note there are some gaps in the detail of the evidence provided.

In addition we identified one recommendation:

Recommendation 4: The template for 'Referral not accepted' should include a signpost to copy the GP into the letter in instances when the GP was not the original referrer

***Key to RAG rating**

The RAG rating is intended to provide an indication only of the status of the action plan against the required actions based on the evidence provided by the Trust at the date of completion of this part of the review. These ratings may change should the Trust be able to share further evidence to substantiate actions noted as having been taken on the action plan update. Additional evidence required is indicated in the table above.

RED	Significant elements of recommended actions not complete and significant gaps in evidence provided by Trust
RED/AMBER	Some actions not complete and significant gaps in evidence provided by the Trust
AMBER	Actions are substantially complete but there are some significant gaps in evidence provided by the Trust
AMBER/GREEN	Actions are complete but there are some minor gaps in evidence provided by the Trust
GREEN	Actions are complete by due date and sufficient evidence has been provided by the Trust

GP letters

Recommendation 4 of the Trust action plan was *"GPs must be informed in writing when a referral is screened and not accepted into the CMHT"*. In order to assess whether letters were being sent, we asked the Trust to provide ten anonymised letters. The Trust gave us a data set containing 1449 cases, held across the eleven CMHTs between 2006 and 2018, from which to draw a random sample.

We set out below detail of the type of letter we wished to review and our selection criteria.

Type of letter	**Filter criteria**
Five anonymised examples of GP's being informed of the CMHT decision not to accept a service user	GP referral, urgent/emergency cases in 2018 to Canterbury CMHT. This generated 35 cases, of which we selected every seventh, resulting in a sample of five cases.
Five anonymised examples of letters sent to the patient's GP after he/she was referred by another team/self referred to the CMHT	Referral to a CMHT, Urgent in 2018. This generated 19 cases, of which every third was selected to produce a sample of five cases.

Please note that a sample of ten can only be used as an indication of performance. It cannot be used to project wider findings.

We gave the Trust ten random case numbers, of which they were able to give us nine letters in response. We were told that there was no evidence in one case that a letter was sent to the GP. The Patient Safety Risk Manager advised that the Service Manager had been informed of this gap and asked to address it.

- Letters to GP in response to GP referral

Letter #	**Addressed to GP**	**Date of referral**	**Date of screening**	**Date of letter**	**Next steps advised**	**Days between referral and response**
1	Yes	12/3/18	15/3/18	16/3/18	Partially (re-refer if concerns inc)	4
2	Yes	3/5/18	4/5/18	4/5/18	Yes	1
3	No – sent to patient	May 2018	N/A – patient did not respond to attempts to arrange an assessment	9/7/18	Yes	Unclear
4	Yes	8/6/18	8/6/18	12/6/18	Yes	4
5	Yes	20/6/18	21/6/18	22/6/18	Yes	2

Four of the five letters reviewed were addressed to the GP. The fifth was addressed to the patient. We are unclear if this version of the letter was copied to the GP.

- Letter to patient's GP after referral from another team/self referral/different GP referral

Letter #	Addressed to GP	Date of referral	Date of screening	Date of letter	Next steps advised	Days between referral and letter to GP
1	No – CC, sent to patient	Unclear who made original referral and when	Unclear – patient spoke to CPN on 15/6/18	26/7/18	Partially	Unclear
2	Yes	Patient self referred in early July	N/A, team unable to make contact	1/8/18	Yes	Unclear
3	Yes (referrer)	8/7/18	9/7/18	10/7/18	Yes	2
4	Yes	Unclear who made original referral and when	N/A – patient accessing private counsellor	10/8/18	Yes	Unclear
5	No letter on file					

The Trust could not locate a letter to the GP in one of the five random cases we selected. Equally our random sample did not generate examples of letters being sent to another team e.g. CMHSOP. With this in mind, and that of the outstanding evidence in relation to the Trust's assurance around this recommendation (e.g. GP audit results), further assurance is required in relation to the Trust's compliance with this aspect of its action plan.

Recommendation 5: The Trust needs to further assure itself, by way of audit, that GPs, patients and referring teams are being informed of a CMHT decision to not accept a patient.

- Engagement with GPs

The interim Service Manager for Canterbury and Coastal CMHT told us steps have been taken to improve the team's dialogue with local GPs. She wrote to all local GPs in February 2018, introducing herself and providing her contact details and those of her two band 7 nurses. The Trust now has nhs.net email accounts which has improved communication (i.e. information can be shared securely electronically). She is meeting with local GPs, some of whom have indicated they wish to undertake some joint working with the CMHT in relation to discussing complex patients (steps are being taken to facilitate this).

The interim Service Manager for Canterbury and Coastal CMHT told us she was confident the team was adhering to the Trust discharge and transfer policy – any exceptions would be picked up through the regular performance monitoring.

9 THE EMBEDDING OF LEARNING AND THE TRUST CULTURE OF SAFETY

The Trust 'Investigation of serious incidents, incidents, complaints and claims policy' (January, 2017) says that after an investigation, recommendations:

"… will be made and from this will be the development of a 'smart' action plan. The action plans will be reported into the Trust Wide Patient Safety and Mortality Review Group who will ensure the lessons learnt and the action plans are shared in all KMPT Care groups. The care group leads will complete the learning through experience template and share with the group

A KMPT wide action plan of themes and lessons learned is put together and information shared and disseminated via the Learning from Experience Group. The Group will also ensure articles go into Team Brief and through the Learning through Experience Newsletters identifying learning from investigations and how this has changed service delivery or practice. Learning will be shared with the wider community through the KMPT website."

The Trust Mortality Review Group (MRG) is responsible for "*ensuring evidence* [from an RCA report] *is available to demonstrate the learning and to monitor and support local groups with the implementation of action plans"*. The MRG is responsible for ensuring learning from RCAs is shared across the Trust, and supports the Learning from Experience Group to ensure learning from serious incidents is available to all staff.

We asked the Trust to provide us with evidence of how it embeds learning across the Trust, both in relation to this specific incident (please see our review of the Trust action plan) and patient safety. The Trust provided us with a great deal of information pertaining to its monitoring of performance at the Trust. Though helpful, the information did not specifically relate to learning from patient safety incidents therefore we have set out this detail in Appendix C.

- A day in the life of a Community Mental Health Team

The Trust has put together a guide for all staff with a view to bringing consistency across the teams, in terms of the Trust's expectations of staff and how staff should be undertaking their roles. The guide contains a CMHT meeting pack, flowcharts describing practice, and letter templates e.g. discharge letter, referral not accepted letter. It also contains the Trust 'DNA' policy. We were told that the guide provides a framework against which CLIQ checks can be undertaken.

The Patient Safety and Risk Manager told us that it had taken time to implement changes within the teams, but she was confident the community teams were clear what was expected of them, and that learning was being implemented. We were told that within the CMHT there had been a drive on assurance and evidence since January/February 2018 and this was coming through to the weekly Care Group meetings. We were told that quality checks (detailed in Appendix C) were starting to have a positive impact on patient safety.

- Thematic review

The Trust provided a document called 'themes learning Jun-Aug 2018' which details a review of cases closed between the aforementioned period. The top themes for learning were:

- Communication (e.g. with the service user)
- Delivery of care (e.g. lack of medical review or follow up, delayed referrals and lack of joint working)

- Clinical practice

The review concluded *"The majority of the actions for implementing the learning appear to be policy or procedure related"*. The document does not set out how the issues would be addressed.

- Patient safety

The Patient Safety and Risk Manager collates learning from serious incidents. This is presented every three months to the Care Group. If the Patient Safety and Risk Manager identifies a theme she will discuss this with the quality leads whom she meets on a monthly basis, in addition to the regular Care Group governance meetings. She can also request that a theme be explored further as part of the month CLiQ checks, if appropriate.
The Trust provided three care group briefings in relation to learning from patient safety incidents:

- Learning from ACG serious incidents January 2018 to June 2018
- Learning from OACG serious incidents July 2017 to July 2018
- Learning from CRCG serious incidents July 2017 to July 2018

For the purpose of this report, we focus on **Learning from CRCG serious incidents July 2017 to July 2018**. The report was compiled by the CRCG Patient Safety and Risk Managers. The briefing details RCA learning reviews submitted to all CCGs between July 2017 and July 2018. The briefing provides a breakdown by quarter of the number of RCA learning reviews, number of learning points identified and number of factors found to be contributory or causal.

15 RCA learning reviews took place in the first quarter of 2018/19, of which all had learning identified and ten had contributory or causal factors.

Factor	**Key issues**	**Summary of Trust Response**
Task	CPA, Recording keeping, risk assessment paperwork	DNA policy rewritten in March 2018, Risk management workshops, monthly care group performance meetings
Work environment	Low staffing, poor systems, inaccurate workload, no care coordinator or delay	CAPA[50] and 'A Day in the Life of' pack introduced. Recruitment and retention within action plan
Team	No supervision, lack of risk planning, absence of MDT approach	Risk management workshops, safety culture workshops, monthly supervision compliance monitored by HR lead
Communication	Patient, with family, internally, externally	Dual Diagnosis event, 'A Day in the Life of' pack, improved systems and consistency across teams including letters to GPs and referrers

[50] The Trust Choice and Partnership Approach

Patient	Dual diagnosis, complex condition/needs, social factors	Dual Diagnosis event, PoSH action plan, KMPT/KCC lead priorities

Four areas were identified in which there had been improvements or were no longer an area of concern: systems and organisation, roles and responsibilities, case load, communication with patient/family.

- Learning events

The Trust provided the slides for an (undated) Patient Safety Learning Event, hosted by the Deputy Director of Quality and Safety. The focus of the event was 'learning from community recovery care group serious incidents'. Summaries of six cases were provided, detailing what happened, the key learning and resultant action taken by the CRCG. Themes across the six cases were identified (e.g. transfers and discharges, communication between teams, non adherence to policy).

The learning event also included 'Learning from CRCG Serious incidents 2017' (similar to that discussed above), detailing RCA learning reviews for four quarters between 2016/17 and 2017/18. It is unclear if Mr D's case was included in the event.

Further presentations at the learning event were: *'Forensic and specialist care group – physical health and clozapine constipation, learning from a patient death'* and '*Venous Thromboembolism (VTE) Prevention*'.

There is extensive evidence the Trust has brought in a number of systems to monitor its performance against various measures and targets, and that it is taking steps to improve how it focuses on key issues (e.g. the revised QPR, CLiQ reports – detailed in Appendix C). In particular the introduction of 'A Day in the Life' pack was designed to ensure consistency in practice and provide staff with clarity around expected standards. The Trust is undertaking work in response to areas of concern including risk management workshops, dual diagnosis workshops, CLiQ checks, Choice and Partnership Approach (CaPA) model implementation and supervision.

However more evidence is required about how the Trust is addressing instances where it is not achieving its QPRs as documented in the monthly performance score card (e.g. crisis plans for all patients) and/or further concerns are identified (e.g. June – August 2018 thematic review – communication and delivery of care). For example, the IQPR performance summary showed the CRCG had not met the performance target of *CPA patients receiving a formal CPA within the past 12 months* on a monthly basis between September 2017 and August 2018 (the timeframe for the scorecard). A number of other indicators (e.g. *percentage of patients with valid CPA care plan or plan of care*) were also highlighted in red for the entire summary scorecard.

The Trust has taken steps to embed learning across the Trust however it is difficult to quantify whether this has led to improved patient safety, based on the evidence provided, and we note there is little evidence of learning from Mr D's case. Leading from this, factors identified as part of the original SI are still being identified in themes. For example, the Patient Safety Learning event identified transfer and discharge and lack of adherence to policy as common themes across the six cases reviewed.

10 ADHERENCE TO DUTY OF CANDOUR

Duty of Candour is a Regulation that states Trust must act in an open and transparent manner – they must engage openly with patients and relatives/carers.

The Regulation[51] says:

1. ***"Registered persons* [or provider] *must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.***

The CQC provides guidance to supplement the regulation, and says in relation to the above:

"Providers must promote a culture that encourages candour, openness and honesty at all levels… Providers should make all reasonable efforts to ensure that staff operating at all levels within the organisation operate within a culture of openness and transparency, and understand their individual responsibilities in relation to the duty of candour, and are supported to be open and honest with patients and apologise when things go wrong"

In the event of a notifiable safety incident, a Trust is expected to notify relevant individuals (e.g. a patient's family) that an incident has happened and provider support. This notification should include an account of what has happened, information about any additional enquiries to be undertaken, and offer an apology. The Trust is required to keep a record of any contact, equally if a third party does not wish to engage, the Trust should log this.

The Trust SI policy references Duty of Candour and advises that patients/relatives must be contacted at the earliest opportunity in the event of a serious incident.

The Trust C*ommunity Engagement Strategy 2016-2020 says:*

> *"KMPT aims to provide services which are open transparent, with a clear commitment to delivering the duty of candour to patients. Services will have respect to the different needs of Kent and Medway using intelligence identified through it demography, perspective of communities, service users, their carers to promote positive health and wellbeing and work towards eliminating stigma."*

Trust adherence to Duty of Candour

The Trust told us that Duty of Candour responsibility sits with and is completed by the Service Managers or Head of Service. The Executive team, particularly the Chief Executive, will write to families in the case of homicides or other high profile SIs. This will be in addition to the Duty of Candour completed by the service looking after the affected person.

The Trust investigation did not contact Mr D, his family or that of the victim, Mr J. The Trust investigation report said it did not have contact details for Mr D's family, nor consent to contact them. The investigation report said that the Trust was liaising with the Police in relation to contacting Mr D's and the victim's family, however the Trust advised us that it had not contacted either family. We were told that they did attempt to contact Mr D's family via the Police, but they did not hear back from the family.

[51] http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour#full-regulation

The Trust advised that systems are now in place to ensure that for future cases, families are sent a personalised letter of condolence. We encourage the Trust to assure itself that the systems in place are adequate to ensure its adherence to Duty of Candour going forward.

The Trust did not adhere to Duty of Candour at the time of the incident because the Police asked the Trust not to contact the victim's family. This was not revisited by the Trust after Mr D's conviction in November 2017. The Trust did not contact Mr D's family before or after his trial, though we note in the context of our own investigation, NHSE have been unable to establish contact.

Recommendation 6: The Trust wide Patient Safety and Mortality Review Group should undertake an audit of the last 12 months of investigations to assure itself that the Trust adheres to Duty of Candour.

11 THE CCG'S QUALITY ASSURANCE PROCESSES IN RELATION TO MR D'S CASE

The terms of reference for this investigation include a review of the CCG's quality assurance process in relation to the serious incident. This included considering whether the CCG was involved in developing the Trust recommendations, the monitoring of the Trust action plan and embedding of learning across the Trust, and any action undertaken to share and embed learning across the local health and social care system.

The NHSE SI framework (2015) says that CCGs are responsible for signing off and quality assuring Trust SI reports:

"On receipt of the final investigation report and action plan from the provider, the commissioner should acknowledge receipt by email. They will then undertake a quality assurance review of the report within 20 calendar days. Where necessary an alternative timescale may be agreed."

Commissioner must ensure:

"the report, action plan and implementation of necessary actions meet the required standard. The serious incident report, closure process and meeting minutes must clearly describe the roles and responsibilities of those involved in the reporting, investigation, oversight and closure of the serious incident to demonstrate good governance and provide a clear audit trail. The commissioner must seek assurance that the report fulfils the required standard for a robust investigation and action plan."

The NHSE SI framework provides a closure checklist which can be completed by providers or commissioners as part of their SI sign off and closure process.

Canterbury and Coastal CCG sign off of Trust internal investigation report
Historically (the CCG is revising its approach – we discuss this below) Canterbury and Coastal CCG had a joint Serious Incident Review Group (SIRG) with Ashford CCG to monitor serious incidents. The terms of reference for the group (dated January 2018 – the CCG did not provide the SIRG ToR in place covering the period in which the SI was reviewed though we note the action plan would have been subject to sign off after this time) set out its purpose as:

"… to ensure that the CCGs have robust systems and processes in place to confirm assurance of the proportionate and robust scrutiny of Serious Incidents. The aim of which is to minimise the risk of recurrence of a similar incident and to assist the CCGs to deliver the statutory responsibilities for care quality, including the domains of safety, effectiveness and patient experience."

The SIRG is responsible for reviewing a serious incident within 20 working days of receipt of a request for closure. The SIRG is tasked with the review and scrutiny of investigation reports and supporting evidence. The SIRG ToR provide a Quality Assurance checklist which it says incidents must be reviewed against prior to the SIRG, and that the SIRG should receive:

"a verbal summary of the incident, investigation and actions planned/completed by the chair"

The checklist considers the phases of investigation including set up, evidence gathering, analysis of evidence and generating solutions. The latter point considers the Trust recommendations and actions as part of this process e.g. "*Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed?"*

A Trust SI investigation can be closed when the SIRG is confident it has full assurance of a robust investigation, action plan and quality improvement. The decisions of the SIRG are reported to the relevant Quality Committee, which in turn is responsible for monitoring the Trust's progress with its action plan.

There is evidence that the Trust submitted a 72-hour report to Canterbury and Coastal CCG and subsequently requested two extensions to the deadline for submission (both of which were granted). The deadline for submission to the CCG was 19 October 2017. The Trust submitted its report, timeline and action plan on 11 October 2017.

The Trust final report was discussed at the Ashford CCG and Canterbury and Coastal CCG joint SIRG on 2 November 2017. The meeting minutes indicate that there was some discussion around the transfer process and contributory factors. It was noted that the action plan was 'smart'. The minutes recorded:

"Recommended for closure. To go to Quality Committee but expect closure after the court case has been completed."

We were told that Trust executive sign off of its internal investigation and action plan would be taken as evidence that a SI could be closed. The SIRG did not complete a Quality Assurance Log and Closure checklist for the Trust investigation.

The SI report, timeline and action plan were included in the 16 November 2017 NHS Canterbury and Coastal CCG Quality Committee board pack. Six items of evidence were included with the submission. These were the items of evidence provided by the Trust to the CCG (and subsequently ourselves) in relation to point one of the action plan (e.g. an email sent by the CMHSOP Assistant Director in August 2017 asking that the action plan be shared with the CMHSOP team). The Quality Committee recommended the SI be closed. The Trust was informed of this decision by email on 18 January 2018.

The Trust SI was discussed at the November 2017 Ashford CCG and Canterbury and Coastal CCG joint SIRG and subsequently closed at the Canterbury and Coastal CCG Quality Committee. The SIRG did not complete a quality checklist and there is no evidence the CCG tested the robustness of the Trust investigation or its action plan. The CCG's decision to close the Trust investigation was not undertaken in line with the SIRG terms of reference or NHSE SI framework.

Monitoring of action plan

The Canterbury and Coastal CCG provided minutes of the KMPT Clinical Quality Review Group (CQRG) dated 10 August 2017. This meeting is attended by representatives from the Trust and CCGs (e.g. East Kent CCG, South Kent Coast CCG and Thanet CCG). It is chaired by the CCG Head of Nursing, Quality and Safety. The minutes demonstrate that serious incident investigations are discussed, but the discussion set out did not pertain to Mr D's case. The minutes do however highlight that there were concerns in relation to how action plans were being monitored. 'Monitoring of SI action plans' was to be added to the meeting's September agenda.

The September 2017 CQRG minutes detail there had been concerns about how the Trust monitored its action plans:

"[Trust Executive Director of Nursing and Quality] *advised KMPT have undertaken a review of SI action plan monitoring. An internal audit has given KMPT limited assurance on closing the loop on action plans and how the evidence is independently verified…* [Trust Deputy

Director of Quality and Safety] *is developing a Standard Operating Procedure (SOP) for managing action plans."*

The Trust Executive Director of Nursing and Quality set out in the meeting that it was intended there would no longer be lengthy individual action plans for each case, but rather an overarching action plan for the Trust. Individual action plans would be managed at care group level whilst thematic actions would be considered on a Trust-wide basis.

We were told that Canterbury and Coastal CCG had not taken steps to monitor the Trust's progress with its Internal investigation action plan. The Trust submitted evidence to Canterbury and Coastal CCG in relation to action one, but not in relation to the other actions. The evidence the Trust provided in relation to action one is the same as that shared with ourselves. We identified gaps in this evidence which we have set out in our review of the Trust's progress with its action plan. There is no evidence that Canterbury and Coastal CCG challenged the Trust in relation to this evidence or the omissions for the outstanding actions. Leading from this, there is no evidence that Canterbury and Coastal CCG was engaging with the Trust in relation to the embedding of learning across the Trust.

We were told that at the time of the incident each CCG had its own processes for following up with SI action plans, though there was no evidence of this. Canterbury and Coastal CCG was unable to provide a clear explanation as to why the action plan had not been monitored.

The 9 November 2017 CQRG minutes detail that the Trust advised it had centrally stored all SI action plans from 1 April 2017 and that the care groups were now in a position to generate reports and have oversight of open action plans. The minutes said there had been concerns about monitoring of action plans, and though actions were being completed locally, there was not Trust-wide learning. The Trust Deputy Director of Quality and Safety said that she had undertaken spot checks of closed action plans to ensure they were robust closed. The minutes said that TIAA had completed a review of the Trust SI action plans and signed off the audit.

The Trust action plan was included in its submission to the NHS Canterbury and Coastal CCG Quality Committee on 16 November 2017. We were not provided with any evidence to indicate the extent to which the SI and action plan were discussed at the Quality Committee.

The CQRG was aware in August 2017 that the Trust had concerns about how it monitored individual action plans. However there is no evidence that Canterbury and Coastal CCG took action in response to this. There is no evidence the CCG monitored the Trust's progress with its action plan for this specific SI, tested the evidence submitted, or reviewed whether the Trust had taken steps to embed learning.

CCG changes

Since April 2018, Thanet CCG, South Kent Coast CCG, Ashford CCG and Canterbury and Coastal CCG – 'East Kent CCGs' - have worked collaboratively under a single managing director and joint Executive Committee with a view to reducing duplication and variation. However each CCG retains its independence and governing body. We were told the four East Kent CCGs are moving to a provider based review process where all SIs pertaining to a provider a reviewed at a single East Kent meeting e.g. all KMPT SIs will be reviewed by one CCG group. It is anticipated that this will allow each group to build up a better understanding of each provider and identify any emerging issues/themes.

Canterbury and Coastal CCG acknowledged it had not reviewed or monitored the Trust SI report or action plan, and that there had been challenges beyond that specific SI. Minutes of

the East Kent Serious Incident Review Group workshop, December 2018, say *"None of the current* [SIRG] *processes fully meet the requirements of the Serious Incident Framework"*. The workshop had recommended that East Kent CCGs move from three to two SIRGS with revised terms of reference, and that each SIRG review specific provider reports. These changes are intended to align the SI review process. The draft terms of reference for the joint serious incident review group were signed off in December 2018 and were scheduled to be implemented in February 2019.

Going forward, once the SIRG closes an SI, it is intended providers will be required to present evidence of its completed action plan to the CQRG. It is also intended that learning from the SI and action plan will go to the relevant monthly CCG (e.g. Canterbury and Coastal CCG) internal Quality Improvement Assurance Group (QIAG), allowing the group to identify themes, risks and good practice. Leading from this, the CCG Quality Improvement Leads and Heads of Quality will work with providers to plan Quality visits. Intelligence collected by these processes will be fed back to the QIAG and link to the CQRG.

We were told that the Trust's CLiQ processes have provided greater assurance in relation to quality monitoring and improvement. Canterbury and Coastal CCG staff will undertake spot checks/quality visits at the Trust, and that Trust staff are invited to present at the CQRG which is also the main vehicle for the CCG to triangulate SIs and look for patterns.

We were told that the four CCGs in East Kent acknowledged the infancy of the new process which was yet to be embedded, but advised TIAA would be commissioned later in 2019 to undertake an audit to ensure recommendations from this Mazars report had been implemented.

The changes at Canterbury and Coastal CCG – as part of East Kent CCGs - remain in infancy, and in some cases are yet to be implemented. It is not possible to evaluate the current/proposed changes and whether these will have a positive impact on the Canterbury and Coastal CCG's ability to monitor SIs and action plans. However the SI framework has been in place since 2013 and Canterbury and Coastal CCG should already have the systems and processes in place to monitor and review SI reports and action plans.

Recommendation 7: Canterbury and Coastal CCG should seek to assure itself, as a priority, that it is signing off Trust SI reports in line with CCG policy and the NHSE SI framework, and that Trust action plans are appropriately tested, monitored and reviewed.

12 APPENDICES

Appendix A

Documents

Trust

- Mr D's clinical notes
- Mr D's primary care notes
- Correspondence between practitioners pertaining to Mr D's care and treatment
- Trust 72-hour report
- Trust RCA and action plan
- Trust updated action plan
- Trust policies, procedures and processes
- Homicide and STEIS flowcharts
- Anonymised patient and GP letters
- Audit results
- Clinical quality checklist
- Community engagement strategy 2016-2020
- QPR action log
- QPR self assessment clinical governance tool
- IQPR performance summary
- KMPT CMHT 'A day in the life of the CMHT' a guide
- IQ performance report (August 2018)
- Themes and learning statement, June – August 2018
- Patient Safety Learning event slides
- Meeting minutes (e.g. IMR, CGRG, locality meetings)
- Internal emails, letters and briefing notes

CCG

- Emails and correspondence
- SIRG meeting minutes
- Reports
- SIRG terms of reference
- Details of evidence submitted by the Trust in relation to the internal investigation and action plan (e.g. emails, meeting minutes and policies)
- Canterbury & Coastal CCG, Quality Committee board pack, November 2017
- East Kent SIRG workshop report, December 2018

Appendix B

Interviewees

- Patient Safety and Risk Manager, Community Recovery Care Group, KMPT
- Interim Service Manager, Canterbury and Coastal CMHT, KMPT
- Deputy Chief Nurse, NHS South Kent Coast Clinical Commissioning Group
- Clinical Head of Quality, East Kent Clinical Commissioning Groups
- Serious Incident Lead, East Kent Clinical Commissioning Groups

Appendix C

Details of the Trust's processes for monitoring performance and practice

- Performance reports

The Trust provided the monthly Integrated Performance Report for August 2018. The report serves as a scorecard across service lines (subdivided by CCG) and also provides a summary report. The scorecard looks at performance across a number of measures – with targets - including Regulatory Targets (e.g. delayed transfers of care), Workforce (e.g. sickness absence) and Quality (e.g. number of home treatment episodes). The scorecard provides the previous month's score by way of comparator, highlights whether the change is an improvement (or not) and sets out the previous 12 months performance, where available.

The Performance report provides clear visual representation of which targets are being achieved and those which are not, in green and red, respectively. We note there are targets not being achieved, and that a Trust summary level these include: the percentage of patients with a valid CPA care plan or plan of care (93.7% against a target of 95%), and patients with crisis plans (94.5% with a target of 95%). The forecast for the following month (September) indicates no change in performance was anticipated, remaining red.

The Community Recovery summary performance scorecard does not provide scores against each indicator for team/CCG though says this is being looked at. Of the 12 Quality indicators that are reported for all CCGs, six were not being met. As is the case with the Trust wide summary, this includes percentage of patients with a valid CPA care plan or plan of care (91.4% against a target of 95%), and patients with crisis plans (92.6% with a target of 95%). Neither target was met across the eight CCGs.

- CLiQ

The Trust has implemented clinical quality checks – CLiQ reports – initially on a fortnightly, but now monthly basis to measure quality. It is relatively new for the 18-65 age group, though has been running for a couple of years in older peoples' services. CLiQ looks at the soft intelligence – concerns - coming into the care groups, and turns these into quality checks which the Quality Leads then assesses on a regular basis. Each team can be measured on compliance against its own triggers/concerns.

The Trust gave us a CLiQ report for Canterbury CMHT, detailing its performance against various indicators between July and October 2018 (five reports). Indicators included compliance with care plan standards, risk assessment, follow-up, supervision, DNAs, and 28 day breach letters. The report highlights green compliance and red non compliance, which can be mapped across the four month period.

The data provided did not indicate an upward trend of improvement – compliance against some indicators improved across the time period, others decreased or fluctuated. The Trust told us that the Board has agreed a range between 60% and 80%, as a measure of performance against the core standards. We were told CLiQ checks require every aspect of the record system to be completed by clinicians to achieve a score of 100% - if a box is left incomplete or there are errors, 100% cannot be achieved.

We set out below an example of the performance against four indicators. The measure of compliance varies with the standard, therefore we have highlighted in bold instances where the team did not achieve full compliance.

Canterbury CMHT CLiQ performance

	Care plan standards	Risk assessment	Supervision	28 day breach letter
16 July 2018	**30%**	**50%**	**50%**	90%
6 August 2018	50%	80%	100%	**60%**
4 September 2018	**40%**	80%	**80%**	80%
26 September 2018	50%	**60%**	100%	90%
29 October 2018	50%	70%	100%	90%

The Trust provided a CLiQ CRCG action plan linked to the CLiQ compliance report/dashboard. The CRCG Service Managers are the lead for the action plan. The action plan we were given was dated 29 October 2018. It detailed areas of non compliance pertaining to individual patients (e.g. *"Care plan has now been reviewed. However there is no Patient View or Crisis Plan. Risk Summary has also been reviewed but it is incomplete…."*). The action plan contains columns for Action, Progress, Evidence and Formal Review dates, however the version we were given did not have any information in these columns.

The interim CMHT Manager told us that her role included acting as quality lead for the CLiQ reports. She explained that in instances of non compliance, she and her quality lead (a band 7 nurse in her team) will go through the CLiQ report and speak to the individuals (e.g. care coordinators) identified. The area of non compliance will then be rechecked as part of the next CLIQ check. She said that typically, the issue would be resolved between the two checks, though there could be the odd ongoing issue (e.g. staff sickness), in which case it would continue to be monitored.

The CLiQ reports go to the monthly Care Group Quality meeting, attended by all service managers for the Care Group, deputy chief operating officer, head of service and associate medical directors. Each CMHT has to present its CLiQ action plan, set out the key issues and explain what steps are being taken to address these.

- Compliance reports

The Community Recovery Care Group (CRCG) has weekly governance meetings that monitor and track compliance for completed paperwork for all new assessments. The Trust has been undertaking weekly compliance reports for the past four to five months. These are separate from CLiQ checks. We have previously described these in the context of the action plan review in the main report.

- Quality Performance Review Group

The CRCG holds a monthly Quality Performance Review (QPR) group. The group, chaired by the Director of Finance (or another Executive Director) has 24 members including representatives from the Care Group Leadership Team and Executive Team. The standing agenda for the meeting focuses on quality, finance, performance and workforce.

The Chair of the QPR wrote to the Care Groups Heads of Service and Care Group Senior Team on 14 September 2018. The letter said review work had taken place, looking at the previous five months QPR meetings and that NHS Improvement (NHSI) had also provided feedback after observing several meetings. NHSI had recommended that the group take steps to focus on key areas of concern, adopt a standardised approach where possible, and that actions from previous meetings are reviewed and updated prior to the next QPR (to

avoid dominating the agenda). As a result, the meeting self-assessment sheet had been revised, placing emphasis on providing a summary of key areas of concern. Each care group was asked to present at the meeting, providing supporting slides that focused on Quality, Workforce, Finance and Performance.

The Trust provided the revised self-assessment commentary sheet for the QPRs which staff are asked to complete detailing any issues or good news in relation to the aforementioned four indicators, the 'top 5 risks and emerging risks, and items for escalation' to the Executive team. We were not provided with minutes for the next QPR or examples of the completed self assessment forms.

We were given a copy of the Community Recovery Care Group (CRCG) QPR action log. It details ten actions added to the log between 25 June and 23 August 2018. The due date for all open actions had passed though there was no indication the items could be closed (i.e. there is a separate list of closed actions which 'open' actions are moved to once completed).

- Survey results

We have reviewed the Trust's performance against NHS England's 2017 Community Survey[52]. The Trust generally scored slightly lower than the national average though there were no significant outliers (e.g. *"In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?"* - the Trust scored 67.9% against a national average of 71.6%). The Trust scored better than the national average in relation to some questions (e.g. *"Do you know how to contact this person* [the person in charge of organising the respondents care and services] *if you have a concern about your care?"* - 96.7% compared to a national average of 74.7%).

The Trust provided its Friends and Family Test and PREM[53] Feedback report for August 2018. The survey looks at six patient experience questions (e.g. *'Do you feel listened to and supported'* and *'Do you feel involved in planning your care').* The questions are measured by the indicators 'always, often, sometimes and never'. Out of 595 respondents (299 from the older care group), 73% or more, responded 'always' to each question.

[52] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/11/Diagnostic-Tool_CMH17_CSV.csv

[53] Patient Reported Experience Measures