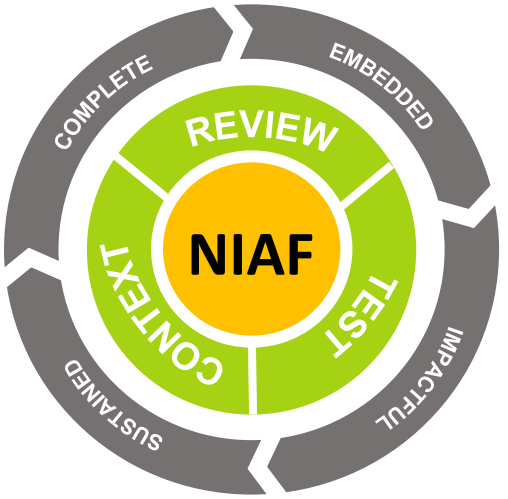
Independent Investigation Assurance Review
Southern Health

Final Report

Private and confidential

Final Draft October 2019

Final Report issued March 2020



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Final Draft Report October 2019.
Final Report issued March 2020.

Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Final Report has been written in line with the terms of reference as set out by NHS England. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (oversees) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This is a confidential Report and is for the sole attention of the project sponsor, NHS England. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. This report was commissioned by NHS England and cannot be used or published without their permission.

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Contents

1. Executive Summary and additional recommendations

Background to the initial event

A service user (P1) had been under the care of Southern Health NHS Foundation Trust mental health services since the age of 17 when he was admitted informally to The Old Manor Hospital for six weeks (Feb 2000). He was then described as actively psychotic. A pattern emerged of mental deterioration followed by hospital admission during which P1's mental health slowly stabilised, leading to discharge into community settings.

Medical staff found it difficult to devise an effective medication regime which P1 would accept and during the period of his care in the community setting he would at various times disengage and reengage with services. Mental healthcare professionals had been attempting to find him for some weeks following his disengagement with services, known non-compliance with medication and escalating concerns being expressed by his mother, housing staff and a local charity.

On 21 March 2017, P1 was detained under Section 136 of the Mental Health Act 1983. On 22 March 2017, a man's body (V1) was found – it was determined in court that he had probably died on the night of 12-13 February 2017. On 30 March 2017, P1 was identified by the police as primary suspect in relation to the 'violent and brutal' death of V1.

Context for this review

In July 2017, the Trust's Clinical Director (CD) for Adult Mental Health (AMH) commissioned an external company, Caring Solutions UK Ltd, to conduct an internal but independent investigation into the care and treatment of a mental health service user (P1) following the homicide of a 37-year-old man (V1) in mid-February 2017. This action was good practice and complies with NHS England's Serious Incident Framework (2015).

The investigation was, however, delayed by attempts to bring P1 to trial for the offence and the police requested the investigators to defer the interviews of Trust staff until after the trial to avoid introducing any bias into the prosecution case. In February 2018 the team were able to commence a review of clinical records that were available, and the police agreed that interviews of Trust staff could commence following the trial of the facts. This was held on 30 April 2018 and resulted in a finding of unlawful killing. The investigation interviews commenced in May 2018 with submission of the final report in December 2018. This included 11 recommendations which were intended to support the Trust in learning, improving services and practices.

Niche Health and Social Care Consulting (Niche) have been asked to provide an assessment of the Trust's resultant action plan against the Niche Investigation and Assurance Framework (NIAF). Also, to review the application of the Duty of Candour with the families of the perpetrator and the victim, and to review the quality assurance processes of the NHS West Hampshire Clinical Commissioning Group (the CCG) in relation to this incident.

Independent internal investigation and implementation of recommendations

The Trust action plan was developed internally following receipt of the internal investigation report and in response to the recommendations made. This report provides a detailed assessment of completion against all actions described in the plan. Our review has found that, as of October 2019, three actions have been progressed to completion (one of which has been marked as completed and closed by the CCG) with a further three actions that were partly complete.

Also, where we could see that actions have been taken to implement the recommendations, we were not always assured that the intended outcomes were being achieved. Of the 11 recommendations, we have rated four as having insufficient evidence to support action progress, five as underway but not yet completed, and two as complete (but not yet embedded or impact demonstrated given that outcomes take time to achieve).

Action owners have been assigned to each recommendation although some have changed following organisational restructuring and the retirement of the CD for AMH in April 2019. As at 25 June 2019, four did not have re-allocated owners despite the retirement and restructuring being planned. Delays in progression have not been escalated to the Trust's Quality and Safety Committee.

Application of the Duty of Candour

Duty of Candour applies when an NHS organisation becomes aware that a notifiable patient safety incident has occurred. Application regarding the perpetrator (P1) was outside of the scope of this work with focus instead on his family and the family of the victim.

P1 and V1's parents do not fulfil the criteria of the definition of a "relevant person" within the Duty of Candour regulations. However, the NHS England Serious Incident Framework confirms that families of both the deceased and the perpetrator should be at the centre of the investigation, fully involved and have appropriate input into the process. The Trust contacted the families of the perpetrator and victim and provided us with a copy of the letters which were sent regarding the internal investigation as evidence that they had fulfilled their 'Being Open' responsibility towards them. In our view, involvement with either family was limited and support absent.

Acknowledging that engagement with both families was complicated by the criminal investigation that ensued from the homicide, and that the Trust's legal services were working with the police liaison officer, the Trust should have ensured more proactive communications at the time of the incident (and in conjunction with the police family liaison officer), and regarding the investigation and its findings.

Also, the families were interviewed as part of the independent internal investigation over a year after the homicide (due to delays in sentencing), but appear to have had little influence on the terms of reference, there were no updates from the independent investigation team once the investigation had begun, and their comments on factual accuracy were not sought.

Further to this, the report findings were not shared with the families (this was because of patient confidentiality i.e. P1 was deemed too unwell by his responsible clinician who felt he would struggle with the decision to consent to the release of the whole report), other than the recommendations which were sent via email by the Trust to the mother of V1; these were essentially meaningless in the absence of a meeting or explanation of their origins. The Trust ensured inclusion of their Caldicott Guardian in decisions regarding the sharing of the report with family members. Recognising the need to maintain confidentiality the Trust should, however, have met with the family of the victim and fed back some of the findings (this could have been achieved without reference to P1's whereabouts or specific details on his mental health). We note that the CCG appeared to support the Trust in their decision not to share the report findings with V1's mother (i.e. for patient confidentiality reasons). This is contrary to good practice and has (understandably) served to prolong the distress of V1's mother.

Clinical commissioning group oversight, governance and systems

NHS West Hampshire CCG provided oversight of the internal investigation action plan with challenge of some actions and requests for audits to ensure that intended outcomes had been achieved with changes embedded in practice. There could, however, have been greater challenge of other actions and whether they addressed the original recommendation, how they would be monitored and tested by the Trust going forward. Equally, we would have expected more robust escalation to the Clinical Quality Review Meeting or the Trust's Executive Team regarding delays in re-allocating action owners following organisational restructuring and retirement of key individuals.
While there is evidence of learning from serious incidents (SIs), this could be more widely proliferated to other health and social care agencies.

Recommendations

We have proposed a number of additional recommendations (ARs) arising from our review and these include:

- **AR 1:** Actions resulting from investigation recommendations should be broken into smaller discreet tasks, each with their own action owner and timelines for delivery (the overall action owner and deadlines should be retained). Actions should also have clear instructions on the methods of implementation, the process for communicating changes to staff (including a description of the staff groups that communications are intended for), the frequency of audit or testing, and how results will be fed back and acted on.
- **AR 2:** Action plans should be captured on a standardised template which clearly assigns initial target dates for completion, revised target dates (and reason for the change), a key for RAG ratings, updates on progress, and evidence to support implementation, testing (e.g. audit) and impact. Action owners need to confirm their accountability for delivery and formal handovers need to be completed prior to changes in postholder positions and before ownership is relinquished.
- **AR 3:** Serious incident action plans should be monitored by an appropriate Executive/management led (Tier 2) quality/governance sub-committee to ensure timely progression and embedding of changes in practice.
- **AR 4:** NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when a serious incident is also being investigated as a serious criminal offence.
- **AR 5:** NHS England should ensure that the Trust immediately applies the principles of open disclosure about the initial independent investigation findings with the families of the victim and perpetrator in line with the NHS England 2015 Serious Incident Framework and the developing Patient Safety Incident Response Framework.
- **AR 6:** The Trust needs to review its processes for the principles of Duty of Candour and Being Open in the case of a homicide, potential criminal activity, or harm to another person who is not a service user. They will need to:
  - evidence early, meaningful and sensitive engagement with affected patients and/or their families/carers, from the point at which a serious incident is identified, throughout the investigation, report formulation and subsequent action planning through to closure of the investigation process; and
  - confirm the role of their Family Liaison Officer in this regard.
- **AR 7:** The CCG needs to implement a process to ensure that material delays in the progression of action plans resulting from serious incidents (to include homicides) are formally escalated to the respective provider at a senior level.
- **AR 8:** Include all appropriate agencies in the circulation of the CCG's quarterly Serious Incident Newsletters.

Review method and quality control

Our work has comprised a review of documents and some staff interviews. It is important to note that we have not reviewed any health care records because there is no element of re-investigation contained within the review terms of reference. We used information from Southern Health NHS Foundation Trust (the Trust or SHFT), NHS West Hampshire Clinical Commissioning Group (the CCG), and V1's mother to complete this review.

At Niche we have a rigorous approach to quality standards. We are an ISO 9001:2015 certified organisation and have developed our own internal single operating process for undertaking independent investigations. Our final reports are quality assured through a Professional Standards Review process (PSR) and approved by an additional senior team member to ensure that they have fully met the terms of reference for review.

2. Summary assessment on progress

The Niche Investigation Assurance Framework

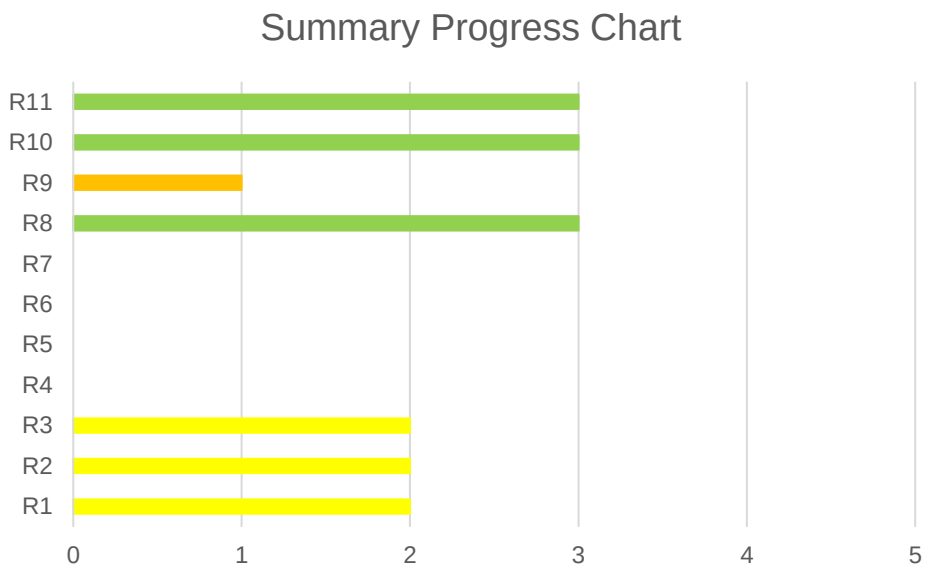
Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a useful numerical grading system to support the representation of 'progress data'. We deliberately avoid using traditional RAG ratings, instead preferring to help our clients to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

Our measurement criteria includes:

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

Our assurance review has focussed on the subsequent action plan, application of Duty of Candour by the Trust to the families of the victim and perpetrator, and assurance of the action plan by the CCG. Terms of reference for this assurance report can be found in Appendix A.

In relation to progression of actions which have been agreed from the 11 recommendations made from the internal investigation report, as of October 2019 we have rated the findings which are summarised below:



Summary

The Trust has made good progress in relation to some actions, however, several actions have stalled because they have been reallocated or there have been other delays in the action planning cycle.

Our additional recommendations should prove useful for the Trust in developing these actions; sufficient engagement and governance is key to the delivery of the entirety of the action plan.

Assurance review findings

3. Assurance review of the internal investigation action plan

The terms of reference for this current assurance review require an evaluation of the Trust's internal investigation report and an assessment of the adequacy of its findings, recommendations and implementation of the action plan in order to identify:

a) **Whether the action plan reflects the identified contributory factors, root causes and recommendations, and those actions are comprehensive.**

The internal investigation was undertaken by an external independent investigation team who identified five patient risk factors and 10 care and service delivery problems but concluded that none of these problems were directly linked to P1's homicide of V1, rather that most were areas which might have influenced the course of events in relation to this specific incident.

Seven other patient factors were also cited as root causes. This is contra to NPSA guidance which states that that '*a root cause is the earliest point (or points) at which action could have been taken that would have stopped the incident happening'*.

RCA techniques were therefore misapplied and these patient factors should, instead, have been considered as contributory factors.

The independent investigation report made 11 recommendations which were intended to support the Trust in learning and improving services and practices. The report reiterates that the issues identified (within the recommendations) did not contribute to the incident and are not causally linked to the unlawful killing of V1.

Our review has found that the recommendations are linked to the care and service delivery problems identified but are in some cases weak.

Recommendation 9, for example, requires the Trust to undertake six monthly auditing. This recommendation would have been more meaningful if written to read: 'All transfers must be accompanied by a comprehensive description of the service user's health and social care needs and risk assessment, including a recorded clinical formulation to assist the CMHT in the planning of future care. Six monthly audits are required to test compliance'.

Similarly, for Recommendation 11 which reads 'when changes to the AMHP Hub are taking place, the Trust to work collaboratively and in partnership with the LA to focus on its capacity and capability to respond to requests for MHA assessments originating from colleagues and fellow practitioners'. Collaboration should, instead, be ongoing and not just when changes to the AMHP Hub are taking place. (Also see commentary opposite on Recommendation 4).

Action plan methodology

Our review has found that actions are brief and, in many cases, do not include the mechanism for implementation or how the impact will be monitored (e.g. through audit, survey or observation). For example, an action for Recommendation 4 says 'the revised process to be communicated to staff' but it does not say how this should be done, to which staff groups and how this will be tested. With some of the other recommendations, the CCG asked for audits rather than this being a part of the initial Trust plan.

There are also some cases where specifics of the recommendation are not addressed. For example, the action for Recommendation 3 says 'the Trust to ensure that there is a robust process of trainee supervision which is an auditable process'.

This does not include any reference to the relapse signature which the recommendation is endeavouring to address, and it does not identify the frequency of audits which will be required or how findings will be monitored going forward.

AR 1: Actions resulting from investigation recommendations should be broken into smaller discreet tasks, each with their own action owner and timelines for delivery (the overall action owner and deadlines should be retained). Actions should also have clear instructions on the methods of implementation, the process for communicating changes to staff (including a description of the staff groups that communications are intended for), the frequency of audit or testing, and how results will be fed back and acted on.

b) Progress made against the action plan accessing appropriate evidence.

Action owners have been assigned to each recommendation although some leads have changed following organisational restructuring and the retirement of the CD for AMH in April 2019. As at 25 June 2019, four did not have re-allocated owners despite the retirement and restructuring being planned.

While the action plan has RAG rated target and completion dates, these are confusing, and it is difficult to assess the status of the actions in terms of completion. Recommendations 7, 9, 10 and 11, for example, have red target dates (with dates that have passed) but green completion (with no dates assigned), while others (recommendations 1, 3, 6 and 8) have no colour ascribed to the target date. There is also no key to support the blue rating of some actions. This is further complicated by some of the recommendations being duplicated in the action plan - duplicated cells have different action numbers, and many have the same text repeated whereas some do not.

AR 2: Action plans should be captured on a standardised template which clearly assigns initial target dates for completion, revised target dates (and reason for the change), a key for RAG ratings, updates on progress, and evidence to support implementation, testing (e.g. audit) and impact. Action owners need to confirm their accountability for delivery and formal handovers need to be completed prior to changes in postholder positions and before ownership is relinquished.

Our full assessment of the progress the Trust has made in making and embedding change can be found from page 12 of this report.

c) Review and comment on processes in place to embed any lessons learnt and determine whether that has had a positive impact on the safety culture of Trust services.

The Trust has a Mental Health Practice Forum which meets each month. We have not been provided with terms of reference for this meeting but a review of meeting minutes has confirmed a lack of clarity on the way that agenda items are agreed. It is not clear, for example, if there are any core standing agenda items such as learning from complaints, litigation or incidents.

We have also been told that the MH Division have deferred recent thematic reviews due to the organisational changes referenced earlier in the report. We have been provided with evidence of hotspot reporting which is good practice but this was dated March 2019.

A Trust-wide Learning from Events; Deaths, Serious Incidents and Complex Complaints Forum has, however, been established which is good practice. This receives updates from specialty Learning from Events, SI, Mortality and Complaints Groups, with proposals for items to be escalated to the Quality and Safety Committee as required.

'Evidence of Improvement Panels' have also been established by the Trust in order to check that actions from serious incidents which have their impact graded as major or catastrophic are embedded. These are chaired by an assigned Executive Director with attendance from a CCG representative. The action plan for this homicide report would not previously have been reviewed when fully implemented; however, the Trust is now including all homicides going forward irrespective of the actual impact grading. Homicide action plans will also be a standing agenda item at these meetings.

d) Review whether the Clinical Governance processes in commissioning, assuring and implementing the RCA findings were appropriate and robust.

As mentioned previously, the CD for AMH Health commissioned an internal but independent investigation into the care and treatment of P1 following the homicide of V1. This was due to the severity of the incident and was good practice which complies with NHS England's Serious Incident Framework. This was signed off at the Trust's Corporate Panel which was chaired by an Executive Director. The Trust accepted the report despite the lack of root cause(s) or contributory factors other than those relating to the patient.

An action plan was agreed in January 2019 with owners and deadlines for completion assigned to each recommendation. The Quality Governance Business Partner for MH/LD/OPMH has taken a leading role in the co-ordination of the action plan which is reviewed at the CCG SI Panel meetings. However, there are no ongoing internal reviews to ensure that actions are implemented in accordance with agreed timelines.

We have been told that areas requiring escalation would be through the Trust's Quality and Safety Committee but no issues have been raised through this forum despite the delays in progressing some of the actions.

AR 3: Serious incident action plans should be monitored by an appropriate Executive/management led (Tier 2) quality/governance sub-committee to ensure timely progression and embedding of changes in practice.

Detailed assessment of actions

Recommendation 1: The Trust should ensure that staff who are not part of the core team (e.g. agency staff, trainees) and are involved with the care and treatment of a person linked to a homicide should be sought out at the earliest opportunity, offered support and be advised that they may be asked to contribute to an investigation. In the case of trainees, this will also include the Trust contacting the Director of Medical Education and the Deanery, in line with their agreed procedures. This to be monitored after every homicide which is reported to the Trust.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1a. The Trust Policy for Managing Incidents and Serious Incidents (SH NCP 16) and the Procedure for Reporting and the Management of Serious Incidents are reviewed to ensure that staff who are involved in the care and treatment of a person linked to a homicide and who are not employee's of the Trust are contacted and supported immediately following a serious incident.	• The action plan states that the Trust Policy for Managing Incidents and Serious Incidents, and the Procedure for Reporting and Managing Incidents will be reviewed after issue of the revised NHS England Serious Incident Framework to ensure that all staff (including those who are not substantive post holders) are supported following a serious incident. The target date for delivery has therefore been amended from July to October 2019.	• The re-set target date for policy review is still ambitious given that the Patient Safety Incident Response Framework has yet to be published and other revisions will need to be included in order to reflect the new guidance. Refreshed policies will then need to be communicated and training offered to ensure full understanding and administration by all staff but there is no detail on this aspect of the policy review process. There is also no reference to any contingencies which have been enacted pending this delayed review.
1b. Ulysses generic 48 hour panel Review Questionnaire and 48 hour Death IMA Review Record to be amended to include a question to identify whether any agency staff were involved with the care and treatment of a person linked to a homicide incident. This should include the names of staff involved and the identified SHFT point of contact for support.	• Incidents are discussed in initial management assessment (IMA) panels as they occur and questions regarding the involvement of staff who are not part of the core team are now included as routine in these meetings. • The Serious Incident checklist on Ulysses also asks if agency/locum staff are involved in the incident.	• This action is complete but has yet to be tested through audit or spot checks to ensure compliance.

Recommendation 1: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
1c. Ulysses generic 48 hour panel Review Questionnaire to be amended to include a question to identify whether any Nursing/Allied Health Professional Students or Doctors in Training roles were involved with the care and treatment of a person linked to a homicide incident. This should include the names of staff involved and the identified SHFT point of contact responsible for informing the teaching body of these staff and support to be offered.	• An Incidents/Red (Internal Investigation using Root Cause Analysis)/Serious Incident process for Doctors in Training was approved in March 2019. This aims to ensure that all doctors in training are adequately included, informed, supported and have opportunities for learning at every stage of the incident process. This is discussed at governance induction sessions for medical staff and the Trust can evidence occasions when escalations regarding permanent and locum medical staff have been made to the Director of Education. • Involvement of junior doctors/students and/or agency staff, and whether they have been given support and interviewed as part of the investigation process, has also been added to the CCG's closure panel check list as part of their serious incident process.	• This action is complete but has yet to be tested through audit or spot checks to ensure compliance.
1b and 1c: This to be evidenced by screen shot from the Ulysses system and monitoring after every homicide which is reported to the Trust.	• This recommendation references staff who are involved in a homicide. Recognising that this type of incident is extremely rare, the Trust has extended its reach to all serious incidents which is good practice	• This process has not yet been tested as it is dependent on a further homicide. The action has been extended to include all serious incidents but has not been tested via an audit or spot check.

NIAF review rating (RR): The Trust has proposed a number of actions (four) to meet this recommendation and there has been some clear progress. However, the overall progress in relation to meeting this recommendation in its entirety and the Trusts ability to demonstrate sustained change is limited.

Overall review rating for this recommendation: 2

Recommendation 2: The CMHT to focus on how they use the resources they have for their higher risk patients. This is in the context of the Trust-wide dependency and acuity review currently being carried out by the Trust, which is intended to enable the Trust to understand the staffing resources they have and how to best deploy them, and to improve the service. This to be subject to peer review six months following the formal acceptance of this report by the Trust and CCG.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• West area to review suitability of the protocol for Shared Care, specifically regarding staffing levels. To make recommendations to Mental Health Governance Meeting for amendments to the protocol if required. • Peer review is to provide evidence and assurance that the protocol for shared care regarding staffing levels is embedded and is in day to day practice.	• An audit of the Winchester Community Mental Health Team (CMHT) was carried out as part of a scheduled peer review in May 2019 and as referenced in this recommendation. This was facilitated by the Governance Assurance Lead for the Mental Health Division and aimed to help the Trust to better understand the staffing resources it has, how best to deploy them and to improve service delivery. This evidenced good joint working arrangements with AMHT, advanced planning of rotas and booking of qualified and experienced staff via NHS Professionals. Other evidence • Safer Staffing reports are reviewed at each Board meeting. In May 2019 it was confirmed that these reports are being reviewed to ensure that caseloads are appropriately mapped to staffing levels.	• Actions for this recommendation have been completed and agreed as closed by the CCG; however, in terms of the acuity and dependency review, the team submitted the required information for 2018 but this was not reviewed under the assessment process and there is no evidence to suggest that anything was done in response to the data that was collected or what it showed. The team is required to complete a new audit for 2019 but this means that it will not have a benchmark by which to compare the results. • The Trust publishes Safer Staffing reports each month, but staff that we spoke with said that there needs to be a further review of the interfaces between crisis teams to ensure resource is appropriately allocated. A new model is currently being trialled in Southampton which is aimed at joining the CMHT with the AMHT which will be rolled out to other teams if successful.

Recommendation 2: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• (continued)	Other evidence (continued) • The Trust also has an intensive support process for managing and responding to staffing shortfalls. This is initiated by a range of factors and early warning scores, and staff that we spoke with could give examples of this working well in practice. • The Trust utilises Divisional and Corporate Risk Registers to escalate concerns about staffing with monthly monitoring at respective Quality and Safety meetings. Andover and Winchester teams, for example, were on the risk register but a new team manager has helped to make some improvements and this risk has now been removed.	• The Trust has 'Learning from Events' meetings where themes are reviewed from SIs. There are proposals for themes to be reviewed from shared care (specialty and Trust-wide) which will test the outcomes of this recommendation but this has yet to be actioned.

NIAF review rating (RR): The Trust has proposed a number of actions (two) to meet this recommendation and there has been some progress and agreement from the CCG. However, there are still some key gaps in assurance in relation to the Trusts ability to demonstrate that they have fully met this recommendation.

Overall review rating for this recommendation: 2

Recommendation 3: When there is clear evidence of a relapse signature, where appropriate, there should be senior medical review of the case utilising supervision of trainees and reflective practice.		
Trust action plan	**Trust response and evidence submitted**	**Niche comments and gaps on assurance**
• The Trust to ensure that there is a robust process of trainee supervision, which is an auditable process.	• The Director of Education has reviewed the clinical supervision process for trainees. Trainees meet each week with their clinical supervisor in protected time and are expected to keep a brief record of these meetings using a set proforma. • Supervisors are now required to attend training and trainees are reminded of the requirements in relation to clinical and educational supervision at their induction. Staff that we spoke with referenced improvements in the quality of supervision offered following the introduction of this formalised training. Other evidence • Trainees are also required to have educational supervision every three months. The Trust has appointed an Education Supervisor in line with Royal College recommendations in order to support this process.	• The processes and training required for clinical and educational supervision of trainees are clear; however, the CCG has asked for an audit to confirm that this is embedded in practice. The format of this audit has yet to be agreed and the target date for completion has therefore moved from March 2019 to 30 September 2019. • We also note an absence of tracking in relation to the supervision that trainees (and other medical staff) receive. Nursing staff and Allied Health Professionals have their supervision recorded on Tableau, but medical staff do not. The Trust is therefore unable to check ongoing compliance rates for this group of staff. • In order to address the source of the recommendation (i.e. discussion and escalation of a relapse signature) supervisors will need to proactively ask if the trainee has any cases which demonstrate this so that they can be discussed accordingly.

NIAF review rating (RR): The Trust has progressed the action to meet this recommendation, however, there are some areas where there may still be gaps in assurance.

Overall review rating for this recommendation: 2

Recommendation 4: At times of high risk e.g. a change of antipsychotic medication, consideration should be given to placing the service user on shared care. This to be subject to annual audit.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
4a. To utilise the standardised process for the use of shared care for those patients who at the point of change of medication should be considered for shared care and for this decision making to be written into their progress notes. 4b. The revised process to be communicated to staff. 4c. A random audit to be carried out to check that this has been embedded into practice.	• No evidence of action implementation or assurance given. Other evidence • Medical staff undertake a risk assessment of a patient when there is a change of medication, but this is part of routine clinical practice rather than an overt formal process. • A letter is also sent to the GP about medication changes with a summary of the risks perceived.	• This recommendation is waiting for reallocation of owner (since April 2019). • The action for this recommendation includes utilisation of the shared care policy and documentation of the decisions made to be recorded in patients notes, with communications and auditing of the process to ensure working in practice. However, these instructions are vague, and no evidence has been provided to support progression or implementation. • The divisional team that we spoke with felt that this recommendation, and particularly the reference to changes of antipsychotic medications (which are frequent), was misleading. • The team reported that the management of the MDT was more important and how patients of concern are discussed, risks captured, actions documented, owned and tracked. In support of this we have been told there has been a recent serious incident requiring investigation which also asked about action tracking for MDTs.

NIAF review rating (RR): The Trust has not provided sufficient evidence to provide assurance that this action has been met, this may be because the recommendation was poorly devised, or it has not been owned or distributed accordingly.

Overall review rating for this recommendation: 0

Recommendation 5: All decisions to place patients in the practitioner-led clinic (formerly the NLC) should be taken in a multidisciplinary forum with consultant psychiatrist input. Due consideration to the risk history should be given. This to be subject to annual audit.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• A review of the Guidance for Clinics held with Adult Mental Health Division (SH CP 210) to include guidance on the decisions to place patient in the practitioner led clinic should be taken in a multi-disciplinary forum with psychiatrist input.	• No evidence of action implementation or assurance given.	• The 'Guidance for Clinics held within the Adult Mental Health Division' that is referred to in the action plan and presented as evidence was authored prior to the homicide investigation report in June 2017 and was due for review in June 2019. The update has been delayed by the organisational restructure that is ongoing. • The guidance requires the leadership team to review the clinics at least annually in a leadership team meeting, considering their effectiveness, staff and service user feedback, incident data and clinic culture. We have not been provided with evidence of these reviews. • This guidance includes a descriptor of the practitioner-led clinics, the competencies required to run them, inclusion and exclusion criteria. It also states the following: 'should it be felt that the needs of a service user would be best met in a clinic, but they may not meet all the criteria, the local clinical judgements should take precedence. It should be agreed by a nurse team leader and a consultant psychiatrist or clinical psychologist and the reasons for this should be documented on RiO'. This does not address the recommendation's requirements for the decision to be made in a multi-disciplinary forum. • Details of practitioner led clinics are being gathered by the Trust in order for the audit standards to be set but this is ongoing.

NIAF review rating (RR): The Trust has not provided sufficient evidence to provide assurance that this action has been met, this may be because the recommendation has not been owned or distributed accordingly.

Overall review rating for this recommendation: 0

Recommendation 6: The Trust reviews the Trust-wide Care Planning Policy and service specific care planning procedures, to ensure that:
- Details of care planning procedures and the Admissions, Discharge and Transfers policy are consistent with each other and implement the same principles.
- There is detailed guidance on technical aspects of CPA processes, such as when to call a CPA review.
- A CPA review is held at key points of a care plan, such as transfer between teams or consultants, changes in medication and decisions to remove a service user from the CPA framework.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• Care Planning Policy (SH CP 82) and Admission, Discharge and Transfer Policy (SH CP 49) will be reviewed to ensure consistency between the policies and to include the following: – Details of care planning procedures and the Admissions, Discharge and Transfers policy are consistent with each other and implement the same principles. – There is detailed guidance on technical aspects of CPA processes, such as when to call a CPA review. – A CPA review is held at key points of a care plan, such as transfer between teams or consultants, changes in medication and decisions to remove a service user from the CPA framework. • This will be evidenced by the approval and ratification of these policies through the MH Governance Meeting. Staff will be informed of the changes through the staff bulletin, team meetings and governance meetings.	• No evidence of action implementation or assurance given; however, there is a good description of the approval process that will be required once the procedures have been reviewed (ratification through the Mental Health Governance Meeting) and mechanisms for communicating the changes made (staff bulletin, team meetings and governance meetings).	• The actions described within the action plan have not been progressed due to changes in personnel following the divisional restructure and a new action owner is currently being assigned. The target date for delivery has therefore been extended to 30 September 2019; however, we believe this now to be ambitious given the scale of review required, the need for consultation on any changes made, and the time for ensuring that the refreshed policy(s) are approved and communicated through the channels described. • The divisional team that we spoke with felt that this recommendation, particularly the reference to a CPA review to be held when a patient is transferred to another team or consultant or there are medication changes (which are frequent) was misleading. Changes in medication do not trigger a CPA review and, recognising that complex cases should have a transfer CPA, we were told this is not always possible as it can delay discharge. There will, therefore, need to be clarity within the policy(s) about the criteria for a CPA review and processes for decision making in this regard.

NIAF review rating (RR): The Trust has not provided sufficient evidence to provide assurance that this action has been met, this may be because the recommendation was poorly devised, or it has not been owned or distributed accordingly.

Overall review rating for this recommendation: 0

Recommendation 7: Documentation should be clear and unambiguous. Recording transfer meetings that did not take place is clearly inaccurate. A panel of representative users of the RiO system should meet and comment on the reliability and accuracy of this means of recording key events in care delivery, particularly focussed on the transfer of care. This panel to report within six months.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust Wide Record Keeping Group to review where Transfer of Care is recorded within the RiO record and to make a recommendation to the Trust to ensure consistent recording of Transfer of Care in the RiO record. • The evidence from this specific action will be monitored and evidenced through the Quality Improvement Plan relating to this specific action within the Care Quality Commission Report.	• No evidence of action implementation or assurance given.	• The recommendation that is captured on the action plan includes an additional sentence which reads 'Details of care planning procedures and the Admissions, Discharge and Transfers policy are consistent with each other and implement the same principles.' • The action for this recommendation will be reviewed by the Trust-wide Record Keeping Group but has been delayed due to a change of action owner following the divisional restructure. A revised target date for completion has not been stated.

NIAF review rating (RR): The Trust has not provided sufficient evidence to provide assurance that this action has been met, this may be because the recommendation has not been owned or distributed accordingly.

Overall review rating for this recommendation: 0

Recommendation 8: The Trust to ensure that before any Trust policy is reviewed, consideration of good practice guidance is included within the template reference.		
Trust action plan	**Trust response and evidence submitted**	**Niche comments and gaps on assurance**
• Trust to review the guidance on Policy Management to ensure that reference to good practice guidance is included in the template for policies, procedures and guidance.	• The Procedure for the Development of Policies is dated June 2016 and is due for review in June 2020. This specifically asks if the policy meets the latest legislation, best practice and guidance with confirmation of this requirement depicted through a quick guide to policy review flow diagram.	• The recommendation that is captured on the action plan includes an additional sentence which reads 'There is detailed guidance on technical aspects of CPA processes, such as when to call a CPA review.' • The action has been implemented but there is no reference to a re-communication of the policy to ensure that authors adhere to this. • Also, 'a spot check of five clinical policies to ensure guidance has been embedded' has been requested by the CCG. The target date has therefore been extended to 30 September 2019.

NIAF review rating (RR): The Trust has progressed the action to meet this recommendation, however, there are some residual areas where there may still be gaps in assurance.

Overall review rating for this recommendation: 3

Recommendation 9: Where appropriate the CMHT sample audit every six months that all transfers are accompanied by a comprehensive description of the service user's health and social care needs and risk assessment, including a recorded clinical formulation to assist the CMHT in the planning of future care.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• The review of the Admission, Discharge and Transfer Policy (SH CP 49) to include the recommendation that a six-monthly audit is undertaken to ensure compliance to Policy. This action is linked to the action of recommendation 6 above.	• An audit proforma is currently being discussed with the CCG (but we have not been provided with a working draft of this).	• The recommendation that is captured on the action plan includes an additional sentence which reads 'A CPA review is held at key points of a care plan, such as transfer between teams or consultants, changes in medication and decisions to remove a service user from the CPA framework.' • This recommendation is waiting for reallocation of owner. • This recommendation is also linked to Recommendation 8 which requires a six-monthly audit to be included in the revised policy document(s). The original target date was 31 May 2019 but a revised date has not been set.

NIAF review rating (RR): The Trust has not provided sufficient evidence to provide assurance that this action has been progressed fully, this may be because it is linked to a separate recommendation which has not been progressed and also because the recommendation has not been owned or distributed accordingly.

Overall review rating for this recommendation: 1

Recommendation 10: The Trust to build on their current work with the Trust-wide Police Liaison Group and to collaborate with the AMHP service, to facilitate:
- An understanding of each other's roles
- Flexibility in approach for complex cases
- A system of escalation within each organisation
- In addition, each agency should consider having a link worker within each organisation, to promote mutual understanding and improved joint working. Progress to be reviewed by all stakeholders within six months of formal acceptance of this report by the Trust and CCG.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• This recommendation to be taken to the Trust Police Liaison Group to review the current work stream to include the following: – An understanding of each other's roles. – Flexibility in approach for complex cases. – A system of escalation within each organisation. – Consideration of Link Worker within SHFT and the AMHP service. • This will be evidenced through the minutes of the Trust-wide Police Liaison Meeting and implementation of the escalation process.	• The Trust has a bi-monthly police liaison group that was established in response to concerns raised by both the Hampshire Police and Trust staff about appropriate use of Police resources. This is chaired by the Deputy Director of Nursing & AHPs and the first meeting was in September 2018. • The Hampshire and the Isle of Wight Section 136 Escalation Process has been submitted as evidence for this recommendation as it includes the escalation processes for SHFT, the police and which AMHP to contact once a person has been detained in a place of safety. • Police link workers have been established. Other evidence • There are also high intensity user groups which facilitate enhanced communications with other agencies and emergency services such as the police and ambulance service. • Staff that we spoke with said that relationships with the police have improved as has the understanding of each other's roles. Police Learning Events have been held to help in this regard.	• Minutes from the September 2018 Police Liaison Group indicate that the purpose of the meeting will be 'reviewed as we go along'. Terms of reference have not been confirmed and the reporting lines for this group are not depicted or clearly understood by staff that we have spoken with. • There has yet to be the formal review of progress which was required as part of the recommendation.

NIAF review rating (RR): The Trust has progressed the actions necessary to meet this recommendation, however, there are some residual areas where there may still be gaps in assurance.

Overall review rating for this recommendation: 3

Recommendation 11: When changes to the AMHP Hub are taking place, the Trust to work collaboratively and in partnership with the LA to focus on its capacity and capability to respond to requests for MHA assessments originating from colleagues and fellow practitioners. The Trust to collect, collate, and record any incident data relating to MHA assessment and feedback to the local authority responsible for the AMHP Hub.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• The Mental Health Act Committee to devise a method to collect, collate and record any incidents relating to the mental health act assessments to feedback to the local authority responsible for the AMHP Hub. This will be evidenced by the committee minutes and the collation of a report to the committee on a quarterly basis.	• Some meetings and discussions about changing of causal groups on Ulysses have been held with agreement that mental health assessment incidents would be reported as they occur rather than quarterly which was proposed as part of the action plan. Other evidence • Staff that we spoke with referenced historic gaps in the AMHP rota and some delays in assessment (these were significant and reported as such). It was felt, however, that these were now much less as AMHPs have changed the way they work.	• Currently, incidents related to mental health assessments are reported in narrative such that themes must be identified manually. Ulysses causal groups are being reviewed so that themes can be more easily extracted but there was agreement in June 2019 that further discussions were required with clinical input to ensure minimal impact on teams when reporting incidents. The new Ulysses environment was confirmed in August 2019 and is currently being tested to ensure appropriate for use going forward.

NIAF review rating (RR): The Trust has progressed the action to meet this recommendation, however, there are some residual areas where there may still be gaps in assurance.

Overall review rating for this recommendation: 3

4. Duty of Candour

National guidance

Duty of Candour applies when an NHS organisation becomes aware of a notifiable patient safety incident. In interpreting the regulation on the Duty of Candour, the Care Quality Commission (CQC) uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

The Regulation is a contractual requirement in the NHS Standard Contract. In order to meet the requirements of this a registered provider is required to:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying out a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

National guidance reiterates that saying 'sorry' is not an admission of liability and is the right thing to do. Also, that healthcare organisations should decide on the most appropriate members of staff to give both verbal and written apologies and information to those involved. This must be done as early as possible and then on an ongoing basis as appropriate.

Duty of Candour is not a statutory requirement to the family of the perpetrator. However, NHS England's 2015 Serious Incident Framework confirms the importance of working in an open, honest and transparent way where patients, victims and their families are put at the centre of the investigation process and must be involved and supported throughout the investigation process. The developing Patient Safety Incident Response Framework supports this principle.

Review the Trusts application of its Duty of Candour with the families of the perpetrator and the victim, identifying any unintended limitations to that application imposed by GDPR legislation and make recommendations for future application of the Duty of Candour in light of new legislation.

The internal investigation report that was undertaken by Caring Solutions has a section on the Duty of Candour and involvement of P1, his family and the victim's family, but this is about their contribution to the report rather than information and communications regarding the homicide itself.

A review of communications and application of Duty of Candour in relation to P1 are not within the scope of our review. We have, instead, been asked to review this in relation to the families of the perpetrator and the victim.

We have not been able to establish contact with P1's mother. NHS England did, however, meet with V1's mother to explain the process of this assurance review and to share the terms of reference. We also met with her in order to ensure that she has a full understanding of our review and to gain her opinion on the Trust communications after the homicide of her son.

We have reviewed the Trust's recording of its actions under the Health and Social Care Act Regulation 20: Duty of Candour and also NHS England's 2015 Serious Incident Framework and have found:

<u>Contact with the family of P1 and V1</u>

The Associate Medical Director (who is also a Consultant Psychiatrist and was the Interim Medical Director (IMD) for the Trust in 2017) contacted P1's mother via a telephone call in June 2017.

The purpose of this call was to explain that an investigation would be commenced in order to determine whether there were any acts or omissions in the care provided to him prior to the homicide. They also issued three letters as follows:

1. October 2017 – an explanation of the delay in the commencement of the investigation due to legal processes but that when able the Trust would provide the contact details of the investigator and further details about the remit of the investigation which the family would be able to contribute to. There was also an offer to speak with the IMD.
2. January 2018 – as above following further delays with conclusion of the trial. There was also an offer to speak with the IMD.
3. May 2018 – confirmation that the investigation would commence and advice on the best way for the independent investigators to contact the family.

Communicating with P1's mother was appropriate, within the spirit of the regulations and in line with the NHS England 2015 Serious Incident Framework. However, according to the information we have been given, initial contact was not made by the Trust until three months after P1 had been identified as the primary suspect in the death of V1, with the first letter not being received for a further four months after that. P1's mother met with the investigation team from Caring Solutions at the start of their review and expressed some concerns about the adequacy of communications and support from the Trust. We agree with her view.

Communications with V1's family were similarly poor. The IMD did not contact V1's parents by telephone after the homicide of their son due to the involvement of the police, but sent similar letters as those received by P1's parents:

[Duty of Candour, continued]

1. September 2017 – condolences and an explanation of the investigation that would be undertaken. There was also an offer to speak with the IMD and contact details given. This was four months after the body of their son had been found by the police and over two months after the arrest of P1.
2. January 2018 – an update and explanation of the delay in the commencement of the investigation and assurance that the Trust would be in touch once this was approved to commence.
3. May 2018 – confirmation that the investigation would commence and advice on the best way for the independent investigators to contact the family.

Recognising the challenges that criminal proceedings can bring to the management of serious incidents and harm, the Trust's communications with the families of P1 and V1 immediately after the event were insufficient and timeframes between letters were over-long. In our view the Trust should have endeavoured to work more collaboratively with the police to ensure that their requirements did not interfere with the obligation of the Trust in relation to 'Being Open'.

We note that the Trust has a Being Open Policy which incorporates the Duty of Candour. This was approved in August 2017 and issued in November 2017. This confirms the requirement to notify 'the relevant person' in person and 'as soon as possible after the incident has been identified'. It does not, however, define what is meant by 'the relevant person', homicide is not referenced within the policy, and it is not clear which of the duties listed within the document would apply to the families of the victim or perpetrator. This is also the case for the CQC's Regulation 20: Duty of Candour document which talks about harm or death of a service user but does not stipulate what is required in the case of harm or death caused by a service user.

In their report, Caring Solutions stated an understanding that the final document would be shared internally with the senior executive team and the Trust Board but also that the Trust would offer to share it with the families of both P1 and V1 if they wished to see it.

The parents of P1 and V1 met with the investigation team from Caring Solutions at the start of their review but there was no follow-up from Caring Solutions or a representative of the Trust to go through the investigation findings in order to allow the families to make any comments or to give a family statement about the impact that the homicide had had on them. Only the recommendations from the resultant report have been shared with the mother of V1 and only via an email rather than a face to face meeting. Neither of the parents have had sight of the whole report despite repeated requests for this from V1's mother.

This was because P1 was considered too unwell by his responsible clinician who felt he would struggle with the decision to consent to the release of the whole report (reference patient confidentiality and GDPR). Advice was sought from NHS England, the Trust's legal team and the Caldicott Guardian; however, nothing further was forthcoming despite the responsible clinician confirming that the victim's family would need some feedback but delivered sensitively and without specific information about P1's whereabouts or mental health.

P1 and V1's parents do not fulfil the criteria of the definition of a "relevant person" within the Duty of Candour regulations. As referenced on page 25, however, Trusts have an official duty to be open and honest with families after a serious incident. The lack of timely initial and ongoing meaningful communications with P1 and V1's parents is contra to the NHS England Serious Incident Framework which is clear that the primary responsibility in relation to serious incidents is from the provider of the care to the people who are affected and/or their families/carers.

[Duty of Candour, continued]

The framework stresses that:

- Patients and their families/carers and victims' families must be involved and supported throughout the investigation process.
- Involvement begins with a genuine apology.
- The victim's family should be fully consulted and involved in the investigation process if they want to be. They should be given the opportunity to ask questions, receive answers, receive updates and full copies of the Trust's internal and independent investigations.

The Trust has a Family Liaison Officer who would normally engage with the families involved in a serious incident but the Trust has told us that they were told not to meet with the family of the victim given that there was an ongoing police investigation. Instead, V1's mother was supported by 'One Hundred Families', by police Family Liaison Officers and Victim Support. P1's mother would not have had any of this support given that she was not perceived to be a victim.

When we met with V1's mother, she was very angry about the lack of communications or support from the Trust. She understood that P1 had some mental health problems and was currently detained in a medium secure setting under a Hospital Order with a Section 41 restriction. She could not understand why she could not see the report or be helped to appreciate what it was that led him to kill her son. The recommendations in isolation of any narrative or explanation have meant very little to her. She said that better awareness of P1's illness and the reasons for the deterioration in his mental health might potentially allow her to empathise with him but that this was not possible without the facts of the case. Instead, the Trust has "*prolonged her anger towards P1"*.

The needs of those affected should be the primary concern of those involved in the response to, and the investigation of serious incidents. In our view, the Trust failed to ensure that any of these actions were fully implemented:

- involvement with either family was limited and support absent;
- there were no updates once the investigation had been initiated;
- a copy of the resultant report was not received or findings shared;
- the needs of the families appear not to have been considered.

We note that the CCG were aware of the concerns raised by V1's mother in relation to the report and its findings not being shared with her, but they appear to have supported the Trust's position on this (i.e. because of patient confidentiality reasons).

Since receipt of our draft assurance report, the Trust has committed to preparing a summary report which will be shared with the victim's family. This will enable them to understand the context and summary background of this homicide and the ensuing recommendations.

AR 4: NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when a serious incident is also being investigated as a serious criminal offence.

AR 5: NHS England should ensure that the Trust immediately applies the principles of open disclosure about the initial independent investigation findings with the families of the victim and perpetrator in line with the NHS England 2015 Serious Incident Framework and the developing Patient Safety Incident Response Framework.

AR 6: The Trust needs to review its processes for the principles of Duty of Candour and Being Open in the case of a homicide, potential criminal activity, or harm to another person who is not a service user. They will need to: evidence early, meaningful and sensitive engagement with affected patients and/or their families/carers, from the point at which a serious incident is identified, throughout the investigation, report formulation and subsequent action planning through to closure of the investigation process; and confirm the role of their Family Liaison Officer in this regard.

5. The CCG quality assurance in relation to this action plan

Responsibility for the quality assurance of action plans resulting from serious incidents at SHFT lies with the CCG. Their Serious Incidents Policy was revised in June 2018 with ratification at their Clinical Governance Committee. This details the mechanism for the performance management of serious incidents requiring investigation reported by the Healthcare Providers (of which SHFT is one) commissioned by the CCG. It includes narrative and diagrammatic representations for the notification and management by the CCG if a serious incident involving a patient occurs and includes homicide by a person in receipt of mental health care within the recent past.

All serious incidents have a timeframe of 60 working days for the completion of investigation reports although extensions to these timescales can be agreed. The circumstances for an extension must be those that are outside the normal working arrangement such as witnesses being unable to be interviewed due to absence or police investigations as was the case for this homicide.

a) The development of appropriate recommendations

Recommendations and action plans from serious investigation reports are signed off by the Trust at their SI Panel with review by the CCG (this process is described in their Serious Incidents Policy).

95% closure is aimed for at first presentation given that they should not be presented without appropriate SHFT Executive Director scrutiny.

The CCG rejects action plans if care or service delivery problems are not reflected in the recommendations or action plans, or if the action plan is not SMART.

Embedded evidence is also requested in order to increase assurance of action implementation and CCG Senior Quality Managers recommend spot checks and audits where required. We have seen evidence of this occurring with the homicide under review although we may have expected more challenge on the report itself given that root causes are assigned to patient factors (see commentary in Section 4). Training on what good evidence looks like has been delivered by the CCG to Trust staff.

b) The monitoring of resulting action plans and the embedding of learning across the Trust

Action plans are monitored at the CCG's SI Panel meetings which are held every fortnight and chaired by the designated CCG Senior Quality Manager for that area. Appropriate representatives from the Trust are invited to attend.

'Evidence of Improvement Panels' have also been established by the CCG in order to check that actions from specific SIs are embedded. The CCG are planning an event in December 2019 for the homicide of V1 as a follow-up.

However, in relation to the internal investigation into the care and treatment of P1, and as described in Section 4, there could have been greater challenge of some actions by the CCG and whether they addressed the original recommendation, how they would be monitored and tested by the Trust going forward. There have also been notable delays progressing the actions – the action plan was agreed in early 2019 and four actions have yet to be progressed. Reasons are multifactorial but largely linked to the organisational restructure of SHFT. Consultation commenced in November 2018 with implementation from April 2019.

[CCG quality assurance, continued]

The CCG Senior Quality Manager has said that realistic deadlines for each of the actions were agreed in January 2019, but senior leaders and action owners have since moved posts or left the Trust resulting in some gaps in attendance at meetings and in relation to progression and implementation.

Minutes from the SI Panel meetings go to the Clinical Quality Review Meetings (CQRM) which are attended by Executive Directors from the Trust. These include some references to delays and changes of action owners but little in the way of escalation or remedial actions required to support timely progression. This is relevant given that action owners are yet to be re-assigned or actions progressed in some cases.

AR 7: The CCG needs to implement a process to ensure that material delays in the progression of action plans resulting from serious incidents (to include homicides) are formally escalated to the respective provider at a senior level.

c) Actions taken to share and embed learning across the local health and/or social care system.

Once actions have been completed for a serious incident, the CCG has a joint meeting with the Trust to go through any relevant learning, and minutes from the meeting are then presented to the relevant CQRM. This has yet to occur for the homicide given that actions are still ongoing.

The CCG can, however, evidence that themes arising from SIs are brought to the attention of individual trusts via quarterly newsletters, although these are not shared more widely (e.g. with local authorities).

AR 8: Include all appropriate agencies in the circulation of the CCG's quarterly Serious Incident Newsletters.

6. Additional recommendations for improvement

No.	Additional recommendation
AR 1	Actions resulting from investigation recommendations should be broken into smaller discreet tasks, each with their own action owner and timelines for delivery (the overall action owner and deadlines should be retained). Actions should also have clear instructions on the methods of implementation, the process for communicating changes to staff (including a description of the staff groups that communications are intended for), the frequency of audit or testing, and how results will be fed back and acted on.
AR 2	Action plans should be captured on a standardised template which clearly assigns initial target dates for completion, revised target dates (and reason for the change), a key for RAG ratings, updates on progress, and evidence to support implementation, testing (e.g. audit) and impact. Action owners need to confirm their accountability for delivery and formal handovers need to be completed prior to changes in postholder positions and before ownership is relinquished.
AR 3	Serious incident action plans should be monitored by an appropriate Executive/management led (Tier 2) quality/governance sub-committee to ensure timely progression and embedding of changes in practice.
AR 4	NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when a serious incident is also being investigated as a serious criminal offence.
AR 5	NHS England should ensure that the Trust immediately applies the principles of open disclosure about the initial independent investigation findings with the families of the victim and perpetrator in line with the NHS England 2015 Serious Incident Framework and the developing Patient Safety Incident Response Framework.
AR 6	The Trust needs to review its processes for the principles of Duty of Candour and Being Open in the case of a homicide, potential criminal activity, or harm to another person who is not a service user. They will need to: • evidence early, meaningful and sensitive engagement with affected patients and/or their families/carers, from the point at which a serious incident is identified, throughout the investigation, report formulation and subsequent action planning through to closure of the investigation process; and • confirm the role of their Family Liaison Officer in this regard.
AR 7	The CCG needs to implement a process to ensure that material delays in the progression of action plans resulting from serious incidents (to include homicides) are formally escalated to the respective provider at a senior level.
AR 8	Include all appropriate agencies in the circulation of the CCG's quarterly Serious Incident Newsletters.

Appendices

A. Terms of reference

1. Purpose of the Review

To independently assess the quality of the action plan developed following the independent level 2 investigation report and the embedding of learning across the Trust and identify, where appropriate any other areas of learning for the Provider(s) 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 Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- 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 accessing appropriate evidence;
- review and comment on processes in place to embed any lessons learnt and determine whether that has had a positive impact on the safety culture of trust services;
- review whether the Trust Clinical Governance processes in commissioning, assuring and implementing the RCA findings were appropriate and robust; and
- make further recommendation for improvement to patient safety and/or governance processes as appropriate.

2.2 Review the Trusts application of its Duty of Candour with the families of the perpetrator and the victim, identifying any unintended limitations to that application imposed by GDPR legislation and make recommendations for future application of the Duty of Candour in light of new legislation.

2.3 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; and
- any actions taken to share and embed learning across the local health and/or social care system.

B. Documents reviewed

Documents reviewed CCG	
181206 SHFT MHLDOPMH SI Panel Minutes APPROVED	190301SHFT MHLDOPMH SI Panel Minutes APPROVED
190411 SHFT MHLDOPMH SI Panel Minutes APPROVED	190426 SHFT MHLDOPMH SI Panel Minutes APPROVED
190509 SHFT MHLDOPMH SI Panel Minutes APPROVED	CCG Assurance of SHFT to CCG July 2017
MHLDOPMH CQRM Minute 190327 APPROVED	MHLDOPMH CQRM Minutes 190529 APPROVED
MHLDOPMH CQRM Minutes 190626 Draft v1	MHLDOPMH Minutes 180627 APPROVED
CGC 170711 Part 2 Minutes APPROVED	Cover sheet for CCG Assurance of SHFT to CGC July 2017
SHFT Mental Health SIRI log 18	WHCCG SI Policy v3.01 June 2018
Documents reviewed SHFT	
Letter to father of victim – 22.5.2018	2017 09 28 – Letter to father of victim
2017 10 02 – Letter to mother of perpetrator	2018 01 02 – Letter to father of victim
2018 01 02 – Letter to mother of perpetrator	2018 01 02 – Letter to mother of victim
2019.01.17 QSM Minutes	September 2017 – Letter to mother of victim
2019.01.17 QSM Agenda	2019.02.21 QSM Agenda
A5 S136 Escalation Protocol V11 (3)	A8 Multi-Agency Section 136 Suite Guide January 2019 v2
SI Action Plan (versions to August 2019)	Senior Leadership Consultation paper final November 2018
Hotspots March 2019 v2	The Being Open Policy (incorporating the legal Duty of Candour) Version: 4

B. Documents reviewed cont.

Documents reviewed SHFT (continued)	
MH Practice Forum Agenda 14 August 2019	MH Practice Forum Agenda 19 June 2019
Options appraisal on future shape of Southern Health NHS Foundation Trust	Police escalation process
Police liaison minutes April 2019	Police Liaison Meeting 16 January 2019
Police Learning Events 3 December 2018, 16 January 2019 – Policies for discussion	Police SHFT Learning Events – dates for diaries
Learning from Events; Deaths, Serious Incidents and Complex Complaints Forum (Trust-wide) terms of reference	Learning from Events; Serious Incident, Mortality and Complex Complaints Forum Agenda 15 October 2019

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