VERITA

IMPROVEMENT THROUGH INVESTIGATION

Follow up review of a statutory mental health independent homicide investigation: Mr D, 2014

Kent and Medway NHS and Social Care Partnership Trust

A report for
NHS England, South region

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1 Introduction

NHS England, South region commissioned Verita to undertake follow up reviews of five statutory mental health independent homicide investigations originally published in 2014.

The purpose of the reviews is to assure NHS England that the recommendations from the investigations have been implemented or are in the process of being implemented. Kent and Medway NHS and Social Care Partnership Trust (the trust) is one of the trusts involved in the follow up reviews.

Kent and Medway NHS and Social Care Partnership Trust (KMPT) was formed on 1 April 2006 after East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust merged. The trust provides mental health, learning disability, substance misuse and other specialist services for 1.6 million people across Kent and Medway.

In this report we review the trust's actions arising from the independent investigation into the care of a Mr D.

Mr D was under the care of the trust from the early 1990s. He was admitted to hospital twice in 1995 under Section 2 of the Mental Health Act (MHA) 1983. The trust diagnosed Mr. D with schizophrenia in 1996. Mr D was admitted to hospital three times between 1996 and 2000. He remained in hospital for much of 2001 and was transferred to a fast-stream rehabilitation unit[1] in December 2002. He was discharged in August 2003 and moved to supported housing. He was transferred to the care of the assertive outreach team (AOT) at the same time.

After further inpatient admissions in September 2002, March 2004 and November 2004, Mr D started on 11 November 2004 to receive a depot[2] of anti-psychotic medication from a depot clinic.

Mr D was moved to unsupported accommodation in a shared accommodation hostel in 2010 because his hostel was closing.

Mr D was compliant with his depot medication at the time of the incident and received his last injection two days before the offence. Mr. D raised no concerns during this appointment.

Mr D attacked a 58-year-old fellow resident who shared his accommodation on 6 March 2011. The man died from his injuries two days later. Mr D pleaded guilty to manslaughter at Maidstone Crown Court on 30 August 2011 and was detained in

[1] Fast-stream rehabilitation is a service which offers intensive support to adults with complex mental health issues and a high level of psychological need for up to a year.
[2] Depot medication is slow release medication given as an injection. Clinics where patients get these injections from qualified nurses are called depot clinics.

October 2011 under the Mental Health Act (MHA) 1983. He was later transferred to the Trevor Gibbons Unit[3], where he remains at the time of this report.

[3] The Trevor Gibbens Unit provides medium secure care (assessment, treatment and rehabilitation) for men and women. The unit has 65 beds. The unit is run by Kent and Medway NHS & Social Care Partnership Trust.

2 Context

The original Verita independent homicide-investigation was completed in August 2014 and sent to the trust and NHS England. Verita and NHS England also presented the findings to the victim's son on 6 November 2014. The report will be published with this follow up review.

Although several important aspects could have improved the way trust services engaged with Mr D, the independent investigation found nothing to suggest that trust staff could have predicted or prevented the homicide.

The recommendations of the independent investigation were:

R1 The trust should assure themselves and the CCG that clients are allocated to the level of CPA in accordance with the trust guidelines. This includes documenting who is responsible for coordination of care and how regularly reviews should be conducted.

R2 The trust should assure itself that the delivery of care and support to an individual complies with CPA guidelines (including care planning, risk assessment and risk management planning). The clinical governance team should audit compliance at least every six months and report its findings to the board.

R3 The trust has introduced guidance to govern the way in which depot clinics are managed. We recommend that the trust undertakes an audit to ensure compliance with the new guidance.

R4 The trust should review the protocols with partnership agencies such as housing services to ensure effective communication and information-sharing for the safety of patients and the general public. This should take place within the next three months.

3 Terms of reference

- To conduct an independent review on the implementation of the action plan following the homicide investigation.

- To inform NHS England and the clinical commissioning group of any concerns resulting from the audit.

- Produce a short report to be shared with stakeholders, including families and published by NHS England, the Trust and the clinical commissioning group.

4 Methodology

Verita wrote to the trust on 5 November 2015 to inform them of the follow up review that NHS England, South region had commissioned and to request an update of how trust action plans had changed since the independent investigation.

The updated action plan they sent was originally created for the trust's internal serious incident report in 2011. The trust's medical director and the KMPT Community Recovery Service Line (CRSL) quality and patient safety lead amended it in October 2014. Actions in the plan were listed in the recommendations from the trust's internal enquiry and did not match the recommendations from the independent investigation.

We fed this back to the trust and NHS England and asked that the trust provide us with a separate account of actions the trust had taken to address the recommendations of the independent investigation as opposed to actions taken to address the trust's internal serious incident report. They provided us a draft action plan in February 2016 and the trust's medical director sent us a final version on 24 March 2016. This action plan is in Appendix A on page 29.

We adopted the following methodology in carrying out our review.

- A review of the original action plan for the trust's internal serious incident review and the additional evidence the trust provided of actions addressing the recommendations of the independent investigation.

- Individual and group interviews with senior staff from the trust's Thanet locality, including KMPT Community Recovery Service Line (CRSL) quality and patient safety lead, KMPT's patient safety manager and a Thanet CRSL senior practitioner.

- A review of the trust's *Care Programme Approach* (CPA) Policy.

- A review of the trust's new guidance on depot clinics ratified in 2013.

- A case review of a random sample of 10 Thanet patients of depot clinics who were under the CPA and also received depot medication. The case review examined if they had:

    - a designated care coordinator;
    - annual CPA meetings that included a review of risk management; and
    - if the records complied with the trust guidance on depot clinics.

- The NHS Thanet Clinical Commissioning Group chaired a *Review of the Independent Investigation into the Care and Treatment of [Mr D]* meeting for NHS England South region on 25 January 2016. Both Verita and senior staff from Kent and Medway NHS and Social Care Partnership Trust attended. They discussed the independent investigation report and the actions the trust took to address the recommendations. The minutes of this meeting are referenced as evidence.

We describe the trust's progress in addressing the four recommendations of the independent investigation report in sections 6 to 8 of this report. Each section sets out the recommendation and gives a short summary of how the original independent homicide investigation arrived at that recommendation. It then examines trust progress in addressing the recommendations.

Because the first two recommendations concern the CPA process, they are discussed together.

Recommendations for further action are given in each section and summarised below.

5 Summary of the trust's progress in implementing its action plan and the follow-up review's recommendations

Recommendations from the independent homicide investigation	Progress and specific findings
Recommendation 1 The trust should assure themselves and the CCG that clients are allocated to the level of CPA in accordance with the trust guidelines. This includes documenting who is responsible for coordination of care and how regularly reviews should be conducted.	*In progress* F1 The trust has an adequate CPA policy. The easily understandable *Care Programme Review Guide* included in the policy is an example of good practice. F2 The trust's CPA policy sets clear standards on how regularly CPA reviews should be conducted and is in line with national guidance. F3 Thanet community services have reduced individual care coordinator caseloads, but the overall number of caseloads remains high. F4 Senior Thanet staff said that the trust was monitoring allocation of care coordinators for patients under CPA, but have not verified this in their audits. Our review of ten cases showed that all had care coordinators allocated on RiO.
Recommendation 2 The trust should assure itself that the delivery of care and support to an individual complies with CPA guidelines (including care planning, risk assessment and risk management planning). The clinical governance team should audit compliance at least every six months and report its findings to the board.	*In progress* F5 The trust audits and benchmarks CPA compliance across the community recovery services. F6 Thanet services have a process to identify and mange poor practice in CPA. F7 A small number of care coordinators in Thanet Community and Recovery Service Line are being performance managed due to poor practice in CPA. F8 A trust wide *Protocol for the escalation of poor practice of CPA review* and Thanet specific *Care Plan Action Plan*, were proposed in January 2016 but have not yet been implemented.
Recommendation 3 The trust has introduced guidance to govern the way in which depot	*In progress* F9 The trust introduced the *Use of intra-Muscular Injection Medication in Community Mental Health*

Recommendations from the independent homicide investigation	Progress and specific findings
clinics are managed. We recommend that the trust undertakes an audit to ensure compliance with the new guidance.	*Clinic Procedure* policy for clinical staff in 2013 on how depot clinics should be managed. F10 We found no evidence the trust monitored this policy in 2014 or 2015. An initial trust audit in 2016 showed that standards are not being met. F11 The examination of records of the Thanet community team for this review found differences in the quality of depot records.
Recommendation 4 The trust should review the protocols with partnership agencies such as housing services to ensure effective communication and information-sharing for the safety of patients and the general public. This should take place within the next three months.	*Not implemented.* F12 After the homicide, the trust reviewed the care of patients who also lived in Mr D's hostel. F13 We found no evidence the trust has reviewed the protocols with partnership agencies like housing services to ensure effective communication and information sharing for the safety of patients and the general public.

Recommendations of this follow-up review

R1 The trust should perform an audit to confirm patients eligible for CPA have been allocated a care coordinator within the next CPA audit cycle.

R2 Thanet senior managers should clarify the maximum caseload size and continue the work to reduce caseloads of CPA coordinators. The managers should report progress to the trust's quality committee on a regular basis.

R3 Thanet senior managers should implement the *Protocol for the escalation of poor practice of CPA Reviews* proposed in January 2016.

R4 The trust board should ensure the proposed quality improvement team audit of services compliance with the *Use of intra-Muscular Injection Medication in Community Mental Health Clinic Procedure* is completed and that an action plan to address failings is compiled by August 2016.

R5 The trust and Thanet clinical commissioning group should carry out the proposal for a Thanet-Wide partnership group. This group should develop or review protocols for inter-agency working and should include housing services.

6 The implementation of recommendations 1 and 2 of the independent investigation

To gather evidence demonstrating the trust implemented recommendations 1 and 2 from the independent investigation we:

- reviewed the trust's CPA policy;
- reviewed the action plans the trust made after the homicide;
- reviewed the audits of CPA the trust provided; and
- conducted a separate review of the CPA and risk assessments for ten clients attending depot clinics.

6.1 Implementation of recommendation 1 from the independent investigation

> Recommendation 1: "The trust should assure themselves and the CCG that clients are allocated to the level of CPA in accordance with the trust guidelines. This includes documenting who is responsible for coordination of care and how regularly reviews should be conducted."

The independent investigation found Mr D was eligible for treatment under CPA for his complex needs but it was unclear from the report and interviews conducted in the investigation what level of CPA he was under. It was also unclear to staff and the investigators who his care coordinator was.

The Care Programme Approach (CPA) is the process services are supposed to use to assess, plan, coordinate and review care for someone with severe mental health problems. The Department of Health provided national guidance for how services should deliver CPA[4]. It says that CPA should be reserved for patients who require ongoing support for complex care needs.

The national guidance also says that a person under CPA should be allocated a named care coordinator (usually a nurse, social worker or occupational therapist) to manage their care plan. The care coordinator should record a care plan to address patients' needs and that the patient and relevant carers (both family and professional carers) are given copies. The national guidance also says the patient should have a formal review of their care at least annually in a clearly recorded CPA meeting.

We reviewed the trust's current CPA policy, which was ratified in October 2015 and is due to be reviewed in October 2018. The policy covered the scope and purpose of CPA and how services should decide if a patient should be on CPA. It also gave clear guidance on the management and recording of CPA reviews.

[4] *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* published by the Department of Health in March 2008. See: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

We found that the trust's policy both referenced the national guidance and included the standards set out in this guidance. The policy also included an appendix called *Care Programme Review* Guide that summarised the key themes of the policy in an easy reading format. We considered this good practice because it covers the main standards of the policy in a reader friendly manner.

Finding

F1 The trust has an adequate CPA policy. The easily understandable *Care Programme Review Guide* included in the policy is an example of good practice.

The national guidance says that CPA review with patients should take place at least once a year[5]. The trust guidance says that patients who are not on CPA but are receiving metal health services[6] should be reviewed every year, but that patients in the community under the CPA should be reviewed at least every six months[7]. In CPA policies from other trusts the general standard for CPA is that they should occur every six months, but at a minimum annually. The Care Quality Commission National NHS patient survey programme also interprets that the national guidance means a CPA review should be performed every 12 months[8]:

> "Guidance on coordinating the care of people who use services as set out in Refocusing the Care Programme Approach says that people receiving care under CPA should receive a formal review at least once a year, although this could be needed more regularly."

Therefore, although the national standard is for an annual review for all patients receiving mental health care, it is fitting that CPA clients of high need are reviewed more frequently.

Finding

F2 The trust's CPA policy sets clear standards on how regularly CPA reviews should be conducted and is in line with national guidance.

One of the difficulties in managing patients on CPA is that care coordinators in a service can have high caseloads. This affects the amount of time and quality of the care they can give. Services struggling to meet the demand of CPA often have individual care coordinators with high caseloads. This was the case for Thanet

[5] Patients can expect a "multi-disciplinary, multi-agency [CPA] review at least once a year" See page 16 of *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*
[6] This is called "standard" care in the KMPT *Care Programme Approach (CPA) Policy*.
[7] "CPA Reviews for CPA Service users in the community must be held…At least every six months." See KMPT *Care Programme Approach (CPA) Policy* Section 18.6 (page 18)
[8] See CQC 2015 Community Mental Health Survey (page 21) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469695/MH15_statistical_release.pdf

services at the time of the Mr D homicide and a finding in the independent investigation. The service had, at that time, resorted to assigning patients on the waiting list for allocation to a CPA coordinator to the service lead clinician. This meant that the lead clinicians recorded as care coordinators for a large caseload were neither expected, nor able to fulfil any care coordination functions.

The independent investigation found that from the time of the incident in 2011 to the independent investigation in 2014, Thanet services had been redesigned to better align trust services with GP practices. The trust describes this as having "pods" where specific teams are linked with specific GP services.

One of the reasons the service was redesigned was to ease the discharge of the less unwell patients from CPA back to standard care under their GP, and so reduce the overall CPA caseload of the team. This meant the caseloads of CPA care coordinators were also reduced and that trust services could better manage the waiting lists.

The independent investigation found that this process had not been completed:

> "Despite considerable improvements to Thanet services, it was evident during our focus group with staff and interviews with senior managers that there is still some way to go to ensure that changes to the service are fully embedded. We heard that although there has been a reduction in the number of cases that are left unallocated, caseloads remain high (70 in some instances) for each staff member. This obviously carries risks in terms of care coordinators being able to manage high caseloads effectively."

Alongside the service redesign in 2011 the senior practitioners of Thanet community mental health services implemented several patient reviews to try to clarify which patients should be managed under CPA and which could receive standard care. This included reviews of patients attending depot clinics. The action plan for the trust's internal serious incident review says that "a number of" patients were reviewed and transferred back to the management of their GP in 2011 and 2012. We have received no information on exactly how many patients were reviewed.

In an interview for this follow-up review, the KMPT Community Recovery Service Line (CRSL) quality and patient safety lead told us that this reviewing of patients has continued and that caseloads for the Thanet community teams are now below 50 per care co-coordinator. The *Review of the Independent Investigation into the Care and Treatment of [Mr D]* in January 2016 confirmed this:

> "Because community teams are not always fully staffed, the allocation of CPA is focused on those individuals who meet the criteria for secondary care services, with referrals to specialist services and discharge to primary care as appropriate. Caseload management is currently below 50 in Thanet, with a drive across the organisation to reduce this further (target 40) through the review and discharge process..."

We found no national agreed policy on caseload size for a community mental health worker. However, there is national guidance on caseload sizes. The Department of

Health Mental Health Policy Implementation Guide: Community Mental Health Teams[9] says:

> "Full time care coordinators to have a maximum caseload of 35 and part time staff to have their caseload reduced pro-rata." (page18)

Based on this guideline, caseload sizes in Thanet remain high and the trust is continuing to try to reduce them further. The goal of reducing the caseload to 40 is still higher than the 35 the guidance indicates. The national guidance also says that the maximum suggested caseload can be "modified" in the light of such factors as:

- complexity of need;
- local demography; and
- the stage of development of other functional teams

However, we have no further information on why the trust has determined their maximum caseload should be 40.

For this review we asked for evidence that the trust was monitoring the CPA policy standards. The trust sent us audits of CPA practice in ten community services, including Thanet Community Recovery service. However, the audits provided examined the frequency and quality of CPA reviews after the reviews had taken place. This means we have not seen evidence of the trust auditing that patients eligible for CPA have been allocated a care coordinator.

For this review we also looked at the CPA records of ten clients on the trust's electronic records system (RiO). These ten clients were selected from a random list of 108 clients who were attending Thanet services depot clinics and were also under CPA.

For all ten patients we found a clear record of a named care-coordinator for each patient. When we cross-referenced these with trust staff attendance at CPA reviews it was clear that not all care coordinators were organising the CPA reviews and that another member of the team had covered this responsibility. We discussed this with Thanet senior managers and they told us that some care coordinators were being performance managed and other staff were allocated to help them manage their caseloads. In these cases, the worker organising the CPA review could be different to the allocated care coordinator. We discuss this further below.

Findings

F3 Thanet community services have reduced individual care coordinator caseloads, but the overall number of caseloads remains high.

[9] See https://www2.rcn.org.uk/downloads/professional_development/mental_health_virtual_ward/treatments_and_therapies/cmhtguidancepdf.pdf

F4 Senior Thanet staff said that the trust was monitoring allocation of care coordinators for patients under CPA, but have not verified this in their audits. Our review of ten cases showed that all had care coordinators allocated on RiO.

Recommendation of this follow-up review

R1 The trust should perform an audit to confirm patients eligible for CPA have been allocated a care coordinator within the next CPA audit cycle .

R2 Thanet senior managers should clarify the maximum caseload size and continue the work to reduce caseloads of CPA coordinators. The managers should report progress to the trust's quality committee on a regular basis.

6.2 Implementation of Recommendation 2 from the independent investigation

> Recommendation 2: "The trust should assure itself that the delivery of care and support to an individual complies with CPA guidelines (including care planning, risk assessment and risk management planning). The clinical governance team should audit compliance at least every six months and report its findings to the board."

The independent investigation found that staff had not regularly reviewed Mr D's care plan or risk assessment. This was poor practice.

As mentioned above, for the purpose of the follow-up review, the trust sent us reports of audits on CPA carried out across the trust. We received details of these audits from the senior manager interviews and the *Review of the Independent Investigation into the Care and Treatment of [Mr D]* meeting held on 25 January 2016. The audits and audit reports we received from the trust are listed in appendix A.

Senior managers told us that the trust's CPA compliance and development manager coordinated the trust audits and reports and was independent of the services audited. They told us that the CPA compliance and development manager also provides CPA training across the organisation.

The trust sent us copies of the CPA audits, including the audit standards for CPA reviews. These were:

1. Does the care plan clearly identify the service user's problems including dual diagnosis?

2. Does each problem have clearly identified interventions, actions and frequency?

3. Does each problem have a clearly identified anticipated outcome and service user views?

4. Are all aspects of the care plan considered with service user involvement?

5. Does each problem identified within the care plan have clear start dates and end (review) dates?

6. Has the service user been offered the opportunity to sign their care plan to indicate that they have agreed to their plan of care?

7. Is there evidence that the service user has been offered a copy of their care plan?

8. Are all clinical risks and risk management plans clearly identified?

9. Is there an advanced care plan and crisis contingency plan?

10. Are all aspects of their care plan up to date and an accurate reflection on the patient's current well-being?

11. Is the care plan simple and straight forward, avoiding any unnecessary and lengthy explanations or narrative?

12. Is the extent of carers' involvement explicit in the care plans?

Senior managers in Thanet told us that the audits are reported to the trust's clinical effectiveness and outcomes group and the trust-wide patient safety group. Both these groups report to the trust's quality committee, which in turn reports to the trust board. This pathway is confirmed on the trust website[10].

The trust's evidence of actions contained a separate audit and report for senior managers about CPA standards. The trust sent us copies of the service evaluations for the trust wide Community Recovery Services (which included the Thanet services) for November 2012, November 2014 and April 2015. As mentioned above, these reports say that to be eligible for audit – a patient must have had a CPA review in the previous year. The audits are therefore of completed reviews.

The most recent service evaluation for April 2015 takes a sample of one hundred and four patients under CPA, randomly selected across twelve trust services. Thanet community recovery service was one of the twelve services. Ten patients from this service were included in the audit.

The criteria for auditing patient notes were:

> "The service user was recorded as CPA on RiO had a CPA Review since the last audit (conducted in January 2015)"

[10] See "Quality Committee" on http://www.kmpt.nhs.uk/about-us/board-committees.htm

The report does not indicate if there were patients under CPA who have not had a review. The specific criteria of the CPA review were:

(1) Was the CPA Review planned in advance?
(2) Was the service user and care coordinator present?
(3) Was the service user involved within their review?
(4) Were the details of the CPA Review correctly recorded on RiO?

The report then grades the reviews under the following ratings:

- Good standard if all audit criteria were met;
- Adequate/ acceptable standard if the majority of the criteria were met "but there was a lack of service user involvement or the review was recorded in the wrong place."; or
- Poor or unacceptable if the patient was not present and this was not explained.

The report published in April 2015 shows that of the ten Thanet patients' notes reviewed, five had a CPA review rating of good and five adequate. No reviews were rated as poor. However, because the audit only examined completed CPA reviews, it may have missed instances where a CPA review had not happened because a care coordinator has not been allocated.

As part of our review of patient records we also examined if annual CPA reviews had taken place in line with national standards. We found that two of the ten patients had not had a review (see Appendix E). We also noted that these two patients had complex mental health needs and that one had command hallucinations with threat to others and we found no record that staff had reviewed this.

We also noted that the patients had the same care coordinator. We later discussed this with senior managers of the Thanet CRSL to obtain information and to allow the patients' care to be reviewed. In this interview, senior managers said they were aware the records of this care coordinator were inadequate, but that they were confident in the care coordinator's clinical skill. They felt we had found a failure in recording rather than care. They told us that the care coordinator was being closely supervised and the records of the patients under their care were being monitored.

We asked for, and were sent, anonymised copies of supervisor records for this care coordinator. These included a detailed review from June 2015 of ten of the care coordinator's patients' records where seven of the ten patients did not have a valid care plan. The trust also gave us summaries of seven monthly supervisor sessions from June 2015 to December 2015 where the focus had been on that care coordinator improving their record keeping. The supervisions record general improvement and that the care coordinator had considered his caseload to be high and difficult to cope with. The records say that there was an ongoing plan to address this through reviewing patients and reallocating them to other care coordinators and assigning other Thanet staff to assist with the caseload.

We asked Thanet senior managers if there were other care coordinators who needed similar supervision and management. They said that there were a "small

number", but also that they had seen improvement in standards overall across the team, as indicated by the trust audit results.

Following our meeting with senior managers we were sent a *Protocol for the escalation of poor practice of CPA reviews*. This protocol is in appendix B and is dated January 2016. The protocol details how services should respond when poor performance is identified through the trust's audit process. We found no further information about whether this protocol has been introduced and, if so, how often poor practice has been identified and reported.

The trust also sent us a Thanet specific *Care Plan Action Plan* dated from January 2016. This is contained in appendix C. Because we received this after the interviews with senior managers, we cannot comment on its implementation or progress of the actions.

Findings

F5 The trust audits and benchmarks CPA compliance across the community recovery services.

F6 Thanet services have a process to identify and mange poor practice in CPA.

F7 A small number of care coordinators in Thanet Community and Recovery Service Line are being performance managed due to poor practice in CPA.

F8 A trust wide *Protocol for the escalation of poor practice of CPA Reviews* and Thanet specific *Care Plan Action Plan*, were proposed in January 2016 but have not yet been implemented.

Recommendation of this follow-up review

R3 Thanet senior managers should implement the *Protocol for the escalation of poor practice of CPA Reviews proposed* in January 2016.

7 The implementation of recommendation 3 from the independent investigation

> Recommendation 3: "The trust has introduced guidance to govern the way in which depot clinics are managed. We recommend that the trust undertakes an audit to ensure compliance with the new guidance."

The independent homicide investigation found that Mr D's major interaction with trust services was when receiving his depot injection. However, we found no trust protocol for how the depot clinic or services should operate, particularly what was expected of staff in terms of providing for therapeutic engagement of patients.

To gather evidence of how the trust has implemented and embedded this recommendation we:

- reviewed the trust's guidance on depot clinics – *Use of Intra-Muscular Injection Medication in Community Mental Health Clinic Procedure;*
- reviewed a trust wide Quality Improvement Project audit of the compliance with the *Use of Intra-Muscular Injection Medication in Community Mental Health Clinic Procedure*; and
- conducted a separate review of the depot clinic entries for ten clients.

The trust action plan says that since the incident, the trust introduced guidance for staff administering depot medication in community teams. We asked for the guidance and the trust sent a copy. This was not a guideline, but a new policy[11] called *Use of Intra-Muscular Injection Medication in Community Mental Health Clinic Procedure*.

The trust created the new policy in 2013. The policy action plan says this was after the independent homicide inquiry. The policy says it was created because:

> "…from recent learning there is a great inconsistency in how the IM [intra-muscular, i.e. depot] clinics operate with service users having variations in the quality and time offered to them."

The lead nurse for the trust's community and recovery service line wrote the policy. It is due for review in October 2016. The policy sets out the purpose, duties and practice expected of staff working in the depot clinics.

The policy also outlines the procedure for physical health checks, monitoring side effects using the Glasgow Antipsychotic Side-Effect Scale (GASS) and what the expected level of interaction between staff and patient whilst administering the injection should be. To reach this level, the policy says staff must do a "review of how the [patient] has been since the last IMI [intra-muscular injection] in relation to their mental health state and any physical health concerns they may have"[12].

[11] Both guidelines and policies seek to simplify a set of processes with regard to an established practice. Guidelines are created to guide staff and do not have to be rigorously followed in all situations Polices, on the other hand, are created to be more binding and must be followed by staff.
[12] *Use of intra-Muscular Injection Medication in Community Mental Health Clinic Procedure* section 6.4.1.

Therefore, the new policy adequately covers the way depot clinics should be managed.

The policy also says how the trust will monitor "compliance with and effectiveness of" the policy within services. It says services should monitor key elements of the policy and reported them annually at the patient safety and clinical governance meeting, which in turn reports to the trust's quality committee, which reports to the board. We found no evidence of any service monitoring or reporting through this route.

As part of the updated action plan for our review the trust sent us a proposal that it had sent to the trust's quality improvement team for an audit of compliance with the policy. This proposal was written on 30 November 2015. It says the reason for the audit was:

> "It has been highlighted through an…Independent Report (Verita November 2014) that the procedures concerning depot injection clinics were not clear and consistent within the Community Recovery Service Lines [CRSL]. Therefore, in 2013 a CRSL Procedure was completed entitled 'Use of Intra Muscular Injection Medication in Community Mental health Clinics', this was agreed at the trust wide patient safety meeting. Following the implementation of this, a project needs to be undertaken to monitor the compliance of this procedure."

The proposal says the planed audit cycle is as follows:

Obtain approval for the project	December 2015
1st cycle data collection	January 2016
1st cycle data analysis	January 2016
Presentation to stakeholders	February 2016
Root cause analysis of poor practice	February 2016
1st cycle action plan produced/implemented	March 2016
1st cycle report (Interim) produced	March 2016
2nd data collection	July 2016
2nd data analysis	August 2016
Presentation to stakeholders	September 2016
Root cause analysis of poor practice	September 2016
2nd cycle action plan produced	September 2016
Final report produced	October 2016

The trust also sent us the interim report for the first cycle of the audit. This interim report was completed in January 2016. Eight standards were audited.

1. All patients must receive specific baseline physical health checks prior to starting depot injections and must be updated yearly.
2. All patients must receive a Glasgow Antipsychotic side effect scale every 6 months.
3. Prior to the administration of the depot injection, there must be a pre-administration discussion between the administrator and patient on their physical and mental wellbeing.
4. Consent must be gained [from the patient] before administration.
5. Where appropriate, a chaperone must be offered [to the patient].

6. All patients must be physically fit and free from illicit drugs and alcohol before receiving their depot injection.
7. All patients who receive a depot injection must have a care plan detailing this intervention.
8. All depot injection medication cards must be clear and legible and contain specific details.

Although these do not include national standards for the management of depot clinics, there are national guidelines on physical health monitoring in the management of schizophrenia from the National Institute for Clinical Excellence (NICE). These audit standards comply with this guidance.

The audit "RAG"[13] rated results against these standards. The results can be seen in appendix D. None of the criteria were RAG rated green, three were rated amber and five red.

The "next step" plans from the audit include: plans to increase awareness of standards, to amend staff medication management training and physical heath training, and to monitor care plans.

As mentioned above, we carried out our own examination of depot clinic entries for the ten patients in our case-note review. We looked for evidence of patient engagement. The results are in appendix E. Our review found differences in the quality of records with:

- three which showed good attention to monitoring and engaging the patient;
- two that were generally basic records about physical health checks and details of the medication but included some notes detailing mental state or social interactions;
- three that were basic and only about physical health checks and details of the medication; and
- two that were of concern because patients had erratic compliance or were requesting a review and there was no record of ongoing monitoring or action to address the patients concerns.

Findings

F9 The trust introduced the *Use of Intra-Muscular Injection Medication in Community Mental Health Clinic Procedure* policy for clinical staff in 2013 on how depot clinics should be managed.

F10 We found no evidence the trust monitored this policy in 2014 or 2015. An initial trust audit in 2016 showed that standards are not being met.

F11 The examination of records of the Thanet community team for this review found differences in the quality of depot records.

[13] "RAG" stands for red, amber and green and gives a rating of the level of compliance against a set standard.

Recommendation of this follow-up review

R4 The trust board should ensure the proposed quality improvement team audit of services compliance with the *Use of intra-Muscular Injection Medication in Community Mental Health Clinic Procedure* is completed and that an action plan to address failings is compiled by August 2016.

8 The implementation of recommendation 4 from the independent investigation

> Recommendation 4: "The trust should review the protocols with partnership agencies such as housing services to ensure effective communication and information-sharing for the safety of patients and the general public. This should take place within the next three months."

The independent investigation found that the trust delegated its responsibility to monitor Mr D's mental health to visiting housing staff. We found no evidence in the clinical notes that any meaningful discussion took place between housing and trust staff. This could have resulted in trust staff failing to notice Mr D's mental health deterioration.

The trust's action plan created after its serious incident review provided evidence that the trust had reviewed the care of patients at the supported housing hostel where Mr D lived at the time of the homicide. This included the agenda of a meeting with an organisation called the Margate Task Force where the incident was discussed. We found no record of who attended this meeting, what was discussed or actions decided on in it. In the action plan were also emails from the Thanet senior practitioner at the time, which show reviews of individual patients at this hostel.

However, the recommendation of the independent investigation requires the trust work with partnership agencies such as the local authority and other housing agents and not just the hostel Mr D was living in at the time of the homicide.

In our interview with Thanet senior managers, they told us further work with partnership agencies was happening through the Thanet Task Force. They said this was a multi-agency task force that focusses on strategies and actions designed to reduce crime and improve the general safety and wellbeing of the population, including monitoring safeguarding in key housing establishments. We were told the membership includes housing agencies, the local council, police, and the trust.

However, the minutes of the *Review of the Independent Investigation into the Care and Treatment of [Mr D]* meeting on 25 January 2016 record that the accountable officer from Thanet Clinical Commissioning Group "felt there might be a misconception in terms of what [the trust] believed the Thanet Task Force could deliver, since it involved two wards in central Margate only."

We subsequently looked for evidence of the Thanet Task Force on the local authority website, but only found evidence of the Margate Task Force. This task force is a multi-agency group that monitors a range of issues affecting the well-being of residents in the Margate Central and Cliftonville West wards of Margate. Because these two wards in Margate are only a part of Thanet, we do not consider the remit of this task force covers the trust services in Thanet.

In the *Review of the Independent Investigation into the Care and Treatment of [Mr D]* meeting on 25 January 2016, the chief of nursing and quality of the Thanet Clinical Commissioning group proposed a joint response to Recommendation 4. This

proposal was for an action plan covering shared care for mental health patients to be linked to the Thanet Health and Wellbeing Board. She said partnership agencies in Thanet attended the Thanet Wellbeing Board and that it had links to general practices in the area. She proposed a mental health work stream and the development of a wide key performance indicator[14] (KPI). We have yet to see further information on this this proposal.

We received no further evidence of protocols or agreements with partnership agencies and none were included in the trust's action plan responding to the original homicide investigation.

Finding

F12 After the homicide, the trust reviewed the care of patients who also lived in Mr D's hostel.

F13 We found no evidence the trust has reviewed the protocols with partnership agencies like housing services to ensure effective communication and information sharing for the safety of patients and the general public.

Recommendation of this follow-up review

R5 The trust and Thanet Clinical Commissioning Group should carry out the proposal for a Thanet-Wide partnership group. This group should develop or review protocols for inter-agency working and should include housing services.

[14] Key Performance Indicators (KPIs) are measures of performance that are used by organisations to measure how well they are performing against targets or expectations.

Appendix A

KMPT ACTION PLAN: VERITA Mr D Independent Inquiry Recommendations

NB. This has been adapted from the trust response. Audits embedded within the response have been removed but are described.

VERITA Recommendations	Actions (As stated by trust)	Evidence to date. (Adapted by Verita)
R1 The trust should assure themselves and the CCG that clients are allocated to the level of CPA in accordance with the trust guidelines. This includes documenting who is responsible for coordination of care and how regularly reviews should be conducted.	1. To audit to provide assurance that the Thanet Client's CPA level and care is in accordance with KMPT's CPA Policy. 2. To audit all aspects of CPA Procedure every six months across all CMHTs within KMPT using an approved Audit Tool.	Trust said that from 2012 to the current date a number of CPA Audits have taken place in the Thanet Locality Community Recovery Service Line (CRSL). The following audits were attached 1. Person Centred Care Plan Audit Results March 2015 2. Person Centred Care Plan Audit Results May 2015 3. Person Centred Care Plan Audit Results June 2015 4. Person Centred Care Plan Audit Results July 2015 The trust said that from 2012 to the current date a number of CPA Review Audits have taken place. Embedded were: 1. Service evaluation of CPA reviews for Thanet, Dover and deal recovery teams within the community recovery service line. November 2012 2. A service evaluation of CPA Reviews for Service Users under CPA – Thanet, Dover, Deal. December 2013

		3. An evaluation on the quality of CPA Reviews within the CRSL. November 2014 4. An evaluation on the quality of CPA Reviews within the CRSL. April 2015.
R2 The trust should assure itself that the delivery of care and support to an individual complies with CPA guidelines (including care planning, risk assessment and risk management planning). The clinical governance team should audit compliance at least every six months and report its findings to the board.	1. To provide evidence and assurance that when a practitioner's competence or practice is called into question by whatever means, there is a robust and proportionate development plan. 2. Lead Practitioners from all Care Coordinating Disciplines to conduct random audits of their professions CPA records for evidence of compliance with the KMPT CPA Policy.	The trust provided the following: • *KMPT CPA Policy*; • Thanet *Protocol for the escalation of poor practice of CPA Reviews*; • Thanet CPA Action Plan; and • Worker specific Action Plans.
R3 The trust has introduced guidance to govern the way in which depot clinics are managed. We recommend that the trust undertakes an audit to ensure compliance with the new guidance.	1. To clarify KMPT Policy and Guidance regarding Medications Management and the specific Policy and Procedure regarding the management of Depot Clinics. 2. To publish the first set of Audit Cycle results conducted in January 2016. o Draft Report now published and embedded in next	The trust provided the following: • The KMPT overarching *Medicines Management Policy* is embedded below: • The KMPT *Procedure for the use of Intra-Muscular Depot Injections*: • Tool for auditing Depot Clinics: • Depot Injection Audit proposal: • Depot Clinic Audit CRSL interim Report – Draft

	Column. This report covers the whole of CRSL and information about Thanet can be extracted from it. ○ The report contains pan-CRSL Recommendations for further Action.	
R4 The trust should review the protocols with partnership agencies such as housing services to ensure effective communication and information-sharing for the safety of patients and the general public. This should take place within the next three months	1. KMPT to review within the next three months its Policies and Protocols partnership working and information sharing with other agencies. This should be conducted with reference to the KMPT *Clinical Risk Assessment and Management of Patients / Service Users*. 2. To conduct this review specifically in collaboration with the Thanet Clinical Commissioning Group.	The trust provided a copy of the *Risk Assessment Policy*.

Appendix B

Protocol for the escalation of poor practice of CPA Reviews

Kent and Medway NHS
NHS and Social Care Partnership Trust

Protocol for the escalation of poor practice of CPA Reviews

1. When a member of the performance team identifies poor CPA Review practice through audit, they will escalate this to the CPA Manager for further investigation and a quality check.
2. If the Review is confirmed as being poor quality, the details of this poor review, including the care coordinator involved will then be escalated by the CPA Manager to the CRSL Assistant Directors, copying in the CRSL Service Line Director and CRSL Business and Service Development Lead and the AD of Performance and Information Management.
3. The Assistant Director will then investigate the poor practice and feedback the outcome to the CPA Manager within 28 days.
4. Where poor practice has been found a new CPA Review must be booked for the service user within 28 days of the investigation occurring. The Performance Team will monitor this and provide assurance to the CPA Manager.
5. The results of CPA audits will be presented to the CRSL CEOG and the CRSL quality meeting and the Trust Wide Clinical Effectiveness Outcome Group by the CPA Manager and shared across all service lines.

January 2016

Appendix C

Care Plan Action Plan

Care Plan Action Plan

January 2016

From the care plan audit over the last year there are a number of key areas that need addressing below is an action plan to address these issues.

- Thanet Senior Practitioner will work individually with staff to assess their competence at completing a care plan, risk assessment, contingency plans. Dates to be booked, Thanet Senior Practitioner has started this process by discussing at the team meeting, POD meetings and Nurses Forum
- Thanet Senior Practitioner will continue to l highlight at the next team meeting on the 9th February areas which need addressing to ensure that the care plan meets the correct standard.
- Areas that need addressing are: start finish dates, carers involvement, risk needs to be highlighted within the care plan and also evidence of the client signing and receiving a care plan.
- Thanet Senior Practitioner is working with the Clinical lead from Ashford and we are peer reviewing the care plan audits any feedback from this audit Thanet Senior Practitioner will continue to give regular feedback to the LLG, Seniors meeting, staff team and on an individual basis to staff when issues are highlighted with their care plans.
- Individual staff that have been identified as not reaching the required level for their documentation are being offered 1:1 support it is also being discussed in their supervision and action plans with targets are being set.
- Staff are encouraged to attend the CPA training that is being offered by the trust.

This is an ongoing action plan and is continually being evaluated and adapted.

Appendix D

Extract from the trust wide Quality Improvement Team *Depot Clinic Audit for CRSL [Community Recovery Service Line's] interim report*: January 2016

Comparison of results against standards taken from the trust's Use of *Intra Muscular Injection Medication in Community Mental Health Clinics* policy.

RAG rating:

Green: 90-100% compliance

Amber: 50-89% compliance

Red: 0-49% compliance

No.	Criterion/Item of information	Compliance 1st data collection
1	All patients must receive the following baseline physical health check prior to starting an depot injections and must be updated yearly: Blood tests (Urea, electrolytes, FBC, blood lipids, LFT and Prolactin) ECG Physical Health Checks (BP, pulse, respiration, height and weight) Nutritional Assessment and Smoking history	
2	All patients must receive a Glasgow Antipsychotic side effect scale every 6 months	
3.	Prior to the administration of the depot injection, there must be a pre-administration discussion between the administrator and patient on their physical and mental wellbeing.	
4	Consent must be gained before administration	
5	Where appropriate, a chaperone must be offered	
6	All patients must be physically fit and free from illicit drugs and alcohol before receiving their depot injection.	
7	All patients who receive a depot injection must have a care plan detailing this intervention.	
8	All depot injection medication cards must be- clear and legible, detailing the following: Service users name and DOB Allergies The charts must be signed with correct name, dosage, date, route and frequency	

Appendix E

Verita Audit of Thanet Community Services records

- Patients randomly selected and all on CPA receiving medication from Depot Clinics.
- Rio Notes accessed on 15 December 2015.

	Pt details	**Care coordinator allocated?**	**Annual CPA as re National Policy?**	**Risk assessment evident at time of CPA**	**Were there clear notes from patient attending Depot Clinic?**	**Additional notes**
1	Female schizophrenia	**Yes**	**Yes** Last CPA recorded 24 November 2015 (previous November 2014)	**Yes** 5 October 2015 (previous 15 October 2014)	**Yes** Including side effects monitoring which was then discussed in CPA. Physical health screening and evidence of monitoring of mental state.	5 Depot notes reviewed
2	Male schizophrenia	**Yes**	**Yes** Last 3 December 2015 (Previous December 2014)	**Yes** 3 December 2015 (Previous 9 December 2014.)	**Yes** Although notes basic and only concerning medication and physical obs.	6 Depot notes reviewed. Good CPA meeting notes -
3	Female schizophrenia	**Yes**	**Yes** Last 24 August 2015 (Previous 22 Jun 2014 and 18 Jun 2013)	**Yes** 24 Aug 2015 (Previous 8 May 2014 and 18 June 2013)	**Yes** Although notes basic and only concerning medication	4 Depot notes reviewed. Resident of supported accommodation.
4	Male Psychosis	**Yes**	**Yes** 20 October 2015	**Yes** 20 October 2015	**Yes** Notes generally basic but	3 Depot notes reviewed

			(Previous 14 November 2014)	(Previous 11 February 2015 and 7 January 2014)	one contained short entry on mood/mental state and some details of carer interactions with patient.	
5	Male Schizophrenia	**Yes**	**No** Did not attend CPA on 3 March 2015. No subsequent entry for follow up.	**No** Although risk assessment completed in February 2015, very little information. Had previously reported commend hallucinations with threat to others and this not reviewed.	**No** Missed 3 depot apt in a row with no indication of what was done to manage apart from inform care coordinator. Prescribed 2 weekly and went from 4 Nov to 9 December without receiving depot. Other notes indicate patient requested to see consultant for medical review but no evidence this has been actioned.	Progress notes show no entries from care co-ordinator since 3 March when Pt did not attend CPA.
6	Male Schizophrenia	**Yes**	**Yes** Last 6 April 2015 (Previous 16 September 2014)	**Yes** Last 14 April 2015 (Previous 16 September 2014)	**Yes** Has had a change in depot following side effects with oral medication. Closely monitored with assistance from carer.	6 Depot records reviewed. Various notes – some very good following change in depot. Prior to that, mostly basic but some mental state assessments.
7	Male Psychosis	**Yes**	**No** Unclear if or when last	**No** Risk information	**No** Notes reflect an erratic	Complex pt. and had been AOT but little evidence of

			seen. Last entry by consultant medical staff on 18 February 2015 – and as emergency. Prior to that 2013.	completed by other agency and not care co-ordinator.	delivery of depot and no indication of action s to address patient non-compliance.	proactive management.
8	Female Psychosis/Mood	**Yes**	**Yes** Last 31 March 2015 + planned medication review with medical team on 14 July 2015 (Previous 11 April 2014)	**Yes** Last 8 October 2015 (Previous 8 July 2015 and 31 March 2015)	**Yes** Some difficulties with depot but closely monitored. Good records including metal state.	4 depot entries reviewed.
9	Male Psychosis	**Yes**	**Yes** Last 27 May 2015 (Previous 5 Jun 2014)	**Yes** Last 27 May 2015 (Previous 16 January 2014)	**Yes** Most entries basic, but some included short description of need and future plans.	9 depot entries reviewed
10	Male Schizophrenia	**Yes**	**Yes** Last 5 Aug 2015 (Previous 11 September 2014)	**Yes** Last 15 February 2015 (Previous 21 October 2014)	**Yes** Although notes basic and only concerning medication and physical obs. Brought to depot clinical by support worker.	6 depot entries reviewed