

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Follow-up review of a statutory mental health independent homicide investigation: Mr M and Mr P, 2014

Sussex Partnership NHS Foundation Trust

A report for NHS England

January 2016

Author:
Geoff Brennan
© Verita 2015

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

This report has been written for NHS England and may not be used, published or reproduced in any way without its express written permission.

Verita
53 Frith St
London W1D 4SN

Telephone **020 7494 5670**
Fax **020 7734 9325**

E-mail enquiries@verita.net
Website Verita

Contents

1	Introduction	3
2	Terms of reference of the follow-up reviews	6
3	Methodology	7
4	Summary of the trust's progress in implementing its action plan and the follow-up review's recommendations	8
5	Implementation of recommendation 1	11
6	Implementation of recommendation 2	17
7	Implementation of recommendation 3	20
8	Implementation of recommendation 4	23
9	Implementation of recommendation 5	26
10	Implementation of recommendation 6	29
11	Physical health checks for patients and staffing	32
	Appendix A	37
	Appendix B	39
	Appendix C	41
	Appendix D	42

1 Introduction

NHS England has commissioned Verita to undertake follow-up reviews of the action taken by trusts in response to the findings of five statutory mental health independent homicide investigations conducted in 2014.

The purpose of the follow-up reviews is to assure NHS England that the recommendations have been implemented or are in the process of being implemented. The terms of reference are given in section 2.

This review looks at the progress made by Sussex Partnership NHS Foundation Trust (the trust) in implementing the recommendations of the independent homicide investigation into the care and treatment of Mr M and Mr P.

1.1 The incident

Mr M and Mr P were both under the care of Jade Ward of the trust's inpatient services at Langley Green Hospital. Mr M absconded from the ward on 8 August 2012. He then met Mr P who was on leave from the ward. They met by chance. They went to Mr M's flat where Mr M killed Mr P. Mr M was found guilty of manslaughter due to diminished responsibility in July 2013.

In May 2014 NHS England commissioned Verita to carry out the independent investigation into both men's care and treatment. The independent investigation was divided into two parts.

- Part 1 - a detailed examination of the events leading up to the incident.
- Part 2 - a thematic review¹ of the clinical records which focused on risk assessment, risk management and the trust's approach to planning care.

Verita's independent investigation concluded that the care provided to both men was seriously inadequate in respect of:

- risk assessment and management;
 - care planning;
 - the use of the Mental Health Act (1983)²; and
 - the response to both Mr M and Mr P leaving the ward on several occasions.
- Other investigations at Langley Green Hospital**

Since the incident and publication of the independent homicide investigation report in July 2014, there have been other reviews of care at Langley Green Hospital. In February and October 2014 the Care Quality Commission conducted routine

¹ The thematic review looked for patterns or 'themes' across a number of clinical records.

² All other references to the Mental Health Act in this report refer to the Mental Health Act (1983)

inspection visits as part of the national monitoring of health services. These visits raised further concerns about patient care.

This and information from their own monitoring of care led to a further review of patient safety at the hospital by Crawley, Horsham and Mid Sussex Clinical Commissioning Groups (CCGs) in December 2014 and January 2015. The CCG commissioned Verita to carry out these reviews on its behalf. The CCG's reviews found that issues with the recording of clinical information identified by both the independent homicide investigation and the Care Quality Commission inspections had not been resolved.

In response, the trust added to the leadership team at Langley Green Hospital. In August 2014, the new leadership team redesigned the Langley Green Hospital Acute Quality and Safety Project Plan, originally introduced in January 2014. The revised plan addressed the issues identified in all reviews and inspections. The progress of this redesigned plan has been monitored by the trust board since October 2014.

The Care Quality Commission completed a follow up review in January 2015. It inspected Langley Green alongside all other acute inpatient care for younger adults in the trust. In the trust- wide report published on 28 May 2015³, the Care Quality Commission summarised its findings of Langley Green Hospital as:

“At Langley Green hospital an independent report was commissioned by NHS England, and published in July 2014, into a murder of one patient by another, both from Langley Green hospital. The report found that the trust had made improvements since the incident. However, a CQC inspection of care in October 2014 found that a number of issues remained outstanding. This inspection [*in January 2015*] has found that many of these have now been addressed.” Care Quality Commission report page 26

The issues identified as being addressed by the Care Quality Commission correspond with those found in part 2 of the independent homicide investigation. We agree with the Care Quality Commission that the trust has made progress in addressing these issues. We have summarised why we have come to this conclusion in appendix A.

Consequently, this review focuses on the trust's implementation of recommendations from part 1 of the independent homicide investigation report.

1.2 Additional issues of quality of care

The trust asked Verita to review two other concerns raised in the reviews in December of 2014 and January 2015:

³[Care Quality Commission follow up report into inpatient care at Sussex Partnership Trust](#)

- the management of physical healthcare; and
- the Langley Green staff recruitment strategy.

We agreed to provide a brief independent overview of the trust's actions against these issues and will deal with them later in the report.

2 Terms of reference of the follow-up reviews

- To conduct an independent review on the implementation of the action plan following the homicide investigation.
- To review and test the trust's governance, assurance and oversight of incidents against the new NHS England serious incident framework.
- 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.

3 Methodology

We asked the trust to provide an updated action plan from the original homicide investigation. This was sent with the Langley Green Hospital Acute Quality and Safety Project Plan. The safety project plan is a spreadsheet recording actions against key targets. This is updated during the weekly review of the plan by the leadership team at Langley Green. We were sent the spreadsheet as of September 2015.

The trust also supplied a number of other supporting documents that are listed in appendix B.

We adopted the following methodology in carrying out our review:

- a desktop review of key documents relating to the trust's action plan drawn up in response to the independent investigation report and the Langley Green Hospital Acute Quality and Safety Project Plan;
- a group interview with senior staff at Langley Green Hospital;
- an interview with the trust's Mental Health Act services team leader(s);
- an interview with the lead for the Triangle of Care interventions for carers;
- a ward visit to review the signage for informal patients;
- a telephone interview with the Sussex Police Mental Health Liaison Officer for Langley Green Hospital;
- a group interview focused on the Langley Green forensic clinics; and
- a case review of a sample of 10 patients across all wards to examine risk assessment and management, Mental Health Act documentation and physical health screening.

We describe progress against each of the six recommendations in detail in sections 5 to 10 of this report. Each section sets out the recommendation and gives a short summary of how it was arrived at in the independent homicide investigation before examining the actions taken by this review to assess progress. Recommendations for further action are given in each section and summarised below.

4 Summary of the trust's progress on recommendations

Recommendations from part 1 of the independent homicide investigation	Progress and specific findings
<p>Recommendation 1</p> <p>The trust should ensure that all staff understand the Mental Health Act, in particular in respect of the criteria for the use of sections 2 and 3.</p>	<p><i>In progress</i></p> <p>F1 At the time of our review 11 of the 32 qualified nurses were up to date with their Mental Health Act training.</p> <p>F2 A timetable was in place for all qualified nurses to be up to date with their mandatory Mental Health Act training by the end of November 2015.</p> <p>F3 The 'Mental Health Act bite-size sessions' run by the Mental Health Act administrators on site could be adapted to include sessions on sections 2 and 3 of the act.</p> <p>F4 The case notes analysis for this review, the Care Quality Commission's reviews and local reviews indicate that staff understand the use of sections 2 and 3 of the Mental Health Act and found no major concerns with administration of the act.</p>
<p>Recommendation 2</p> <p>The trust should further review the AWOL [Absent without leave]/missing person's policy in conjunction with Sussex Police and should ensure that staff in both organisations understand its operation.</p>	<p><i>Implemented</i></p> <p>F5 Sussex Partnership NHS Foundation Trust and Sussex Police have developed a joint absent without leave/missing person's policy.</p> <p>F6 The police and the trust monitor the use of the absent without leave/missing person's policy in the monthly Mental Health Act Monitoring Meeting.</p>
<p>Recommendation 3</p> <p>The trust should assure itself that informal patients are not detained illegally.</p>	<p><i>Not implemented</i></p> <p>F7 This review found an informal patient was de facto detained as defined by the Care Quality Commission.</p> <p>F8 The trust's review of revised multidisciplinary clinical review paperwork had not recognised the fact of detention of an informal patient.</p>
<p>Recommendation 4</p>	<p><i>Implemented and ongoing?</i></p>

Recommendations from part 1 of the independent homicide investigation	Progress and specific findings
<p>The trust should issue guidance to staff on the need to ensure that all risks are clearly set out in the risk management plan and communicated to staff. The trust should also ensure mechanisms are in place to make sure this happens.</p>	<p>F9 The trust has issued guidance to staff on conducting weekly patient reviews. This guidance states that risks and mental health presentation should be reviewed.</p> <p>F10 The trust has a mechanism to monitor the overall guidance, including the recording and managing of risk.</p> <p>F11 An analysis of case notes carried out for this review indicated the guidance was followed for nine of the 10 cases examined.</p>
<p>Recommendation 5</p> <p>The trust should establish a process with the police, probation and prison services for rapidly obtaining information about forensic histories and index offences where patients are deemed to be a risk to others.</p>	<p><i>Implemented</i></p> <p>F12 There is a clear process for staff to access relevant information from ViSOR⁴ data on the Police National Computer which is updated by the police, probation and prison services.</p> <p>F13 There is evidence that staff request information for patient risk assessments from the Police national Computer.</p> <p>F14 The newly introduced forensic clinics to support and advise ward staff are an example of good practice.</p>
<p>Recommendation 6</p> <p>The trust should ensure that staff routinely involve families in discussions and decisions about a patient's care, in line with trust policy.</p>	<p><i>In progress</i></p> <p>F15 The trust does not have a mechanism to monitor the inclusion of carers in patients' care.</p> <p>F16 Langley Green Hospital is implementing the Triangle of Care guidance and the inclusion of carers in training is an example of good practice.</p>

⁴ ViSOR stands for "Violent and Sex Offenders Register".

Follow-up review's recommendations

R1 The leadership team and ward managers should assure themselves that all qualified nurses have completed their Mental Health Act training and devise a mechanism to ensure they remain up to date.

R2 The multidisciplinary meetings on the ward should review all informal patient records to ensure that none are de facto detained as defined by the Care Quality Commission.

R3 If an informal patient is found to be de facto detained, their care should be reviewed and a clear record made of their status under the Mental Health Act. This should be communicated to the patient.

R4 The monitoring of informal patient records should be carried out by the Mental Health Act administrators.

R5 The leadership team should devise a mechanism to monitor the inclusion of carers in patient care.

5 Implementation of recommendation 1

The trust should ensure that all staff understand the Mental Health Act, in particular in respect of the criteria for the use of sections 2 and 3.

The independent homicide investigation found that Mr M should have been assessed for detention under the Mental Health Act. When interviewed, qualified staff were unclear about the use of sections 2 and 3 of the act, which are those sections that allow for detention.

Mental health trusts assure themselves that staff understand the Mental Health Act by providing:

- mandatory Mental Health Act training for qualified staff who are responsible for administering the act; and
- checks on the administration of the Mental Health Act to provide assurance that staff understand and are complying with the act.

Nationally, the Care Quality Commission monitors how clinical services comply with the administration of the Mental Health Act.

To assure actions against this recommendation we:

- interviewed senior staff including the Mental Health Act services team leader for Langley Green Hospital;
- reviewed the training records of qualified nurses at Langley Green Hospital;
- reviewed the Mental Health Act documentation as part of our case notes review;
- reviewed reports of two Care Quality Commission Mental Health Act (unplanned monitoring visits⁵ (Opal Ward on 11 May 2015 and Coral Ward on 17 August 2015); and
- reviewed local arrangements for checking Mental Health Act documentation.

⁵ Under the Mental Health Act 1983, the Care Quality Commission has a duty to monitor how services in England exercise their powers and discharge their duties in relation to patients who are detained in hospital under the act. It does this by conducting and reporting planned and unplanned visits to services.

5.1 Staff Mental Health Act training

5.1.1 Mandatory training

Senior staff and the lead for the Mental Health Act told us that trust policy says that qualified nurses should attend a mandatory one-day training session on the act once a year.

When interviewed, senior staff told us that Langley Green had experienced a high turnover of all staff since the homicide and had found it difficult to fill the vacancies. This was also mentioned in the reports of both of the unplanned monitoring visits by the Care Quality Commission.

Senior staff told us the turnover and recruitment of new staff has led to a delay in ensuring qualified staff have received adequate training on the act, including the criteria for sections 2 and 3.

We were provided with a copy of the latest programme for training of 32 qualified nurses working at Langley Green Hospital. This recorded when each nurse was last trained and the timetable for forthcoming training.

Eleven qualified nurses were up to date with their training at the time of the review. The programme of planned training sessions showed all 32 qualified nurses would be up to date with their training by the 25 November 2015.

The Langley Green Hospital Acute Quality and Safety Project Plan monitors staff training for the hospital, but it does not contain detail of how many staff have completed the Mental Health Act training.

We asked for details of the content of the training. The Mental Health Act services team leader told us that the training was run by a qualified Mental Health Act solicitor independent of the trust and covered all sections pertinent to inpatient care, including sections 2 and 3.

5.1.2 Inhouse training

The Mental Health Act services team leader told us that administrators under her management provided short session on the wards for staff. These were called 'Mental Health Act bite-size sessions'.

The session lasts for 10 to 20 minutes and cover a single aspect of the Mental Health Act in each session. We were given the example of a session on 'how to check if the Mental Health Act documentation on admission is correct'.

We asked the Mental Health Act services team leader if these bite-size sessions covered the use of sections 2 and 3 or the rights of informal patients. We were told

that these subjects were not included, but that the bite-size sessions could be adapted.

However, we were told that one of the two Mental Health Act administrator posts had been vacant for several months which had led to the suspension of the bite-size training sessions. They had recently resumed after the post was filled.

5.1.3 Findings

F1 At the time of review 11 of the 32 qualified nurses were up to date with their Mental Health Act training.

F2 A timetable was in place for all qualified nurses to be up to date with their mandatory Mental Health Act training by the end of November 2015.

F3 The 'Mental Health Act bite-size session' run by the Mental Health Act administrators on site could be adapted to include sessions on sections 2 and 3 of the act.

5.1.4 Recommendation

R1 The leadership team and ward managers should assure themselves that all qualified nurses have completed their Mental Health Act training and devise a mechanism to ensure they remain up to date.

5.2 Monitoring compliance with the Mental Health Act at Langley Green Hospital

The Mental Health Act services team leader told us that the main role of the Mental Health Act administrators was to monitor compliance with the act by checking all documentation on a patient's admission, carrying out further checks while an inpatient and ensuring any Mental Health Act tribunal or managers' hearings were in compliance with the act.

The team leader felt that the single Mental Health Act administrator had been able to ensure that standards of monitoring had been met while the department was understaffed.

5.3 Care Quality Commission Mental Health Act monitoring visits

The Care Quality Commission is required to monitor the use of the Mental Health Act to provide a safeguard for individual patients whose rights are restricted under the act. The Care Quality Commission does this with unannounced visits to wards to check documentation and interview detained patients and ward staff.

We were provided with the written Care Quality Commission reports for two such unannounced visits to:

- Opal Ward on 11 May 2015; and
- Coral Ward on 17 August 2015.

5.3.1 *Opal Ward on 11 May 2015*

On the day of the visit six of the 15 patients on the ward were detained under the Mental Health Act. When asked, none of the detained patients wanted to meet the Care Quality Commission inspectors.

The inspectors reviewed four sets of notes for detained patients. With regard to the act, they found that one was missing the Approved Mental Health Professional report at the time of admission. The inspectors' report also noted that there were failings in two sets of notes about the proper recording of leave entitlement under section 17 of the act.

However, the report stated that all notes reviewed showed patients were being informed of their legal rights appropriately and that steps were being taken to repeat these rights for patients who lacked the capacity to understand them. The report showed that the inspectors had no concerns with staff understanding the act.

5.3.2 *Coral Ward on 17 August 2015*

On the day of the visit nine of the 19 patients on the ward were detained under the Mental Health Act. Three of the detained patients agreed to meet the Care Quality Commission inspectors.

The inspectors reviewed five sets of notes for detained patients. With regard to the act, they found that one was missing the Approved Mental Health Professional report at the time of admission and that one set of notes had incorrectly recorded next of kin details.

However, the inspectors' report also stated that all patients were being informed of their legal rights appropriately; that all had been assessed for their capacity to understand their treatment options; and all had been informed of their right to access an Independent Mental Health Advocacy Service⁶. The report indicated that the inspectors had no concerns with staff understanding the act.

The report also noted that patients' leave under section 17 of the Mental Health Act had improved since the last visit to the ward on 16 August 2012.

Both of the reports on the Care Quality Commission's Mental Health Act monitoring visits confirmed that there was an internal trust system to 'scrutinise the [Mental

⁶ The trust has commissioned an Independent Mental Health Advocacy Service for Langley Green Hospital managed by the charity Mind. The service helps patients' know their rights under the law and assists them in getting answers to any questions they may have about their care and treatment.

Health Act] detention documents' and that these documents were easy to find in the notes.

5.4 Case notes review

On 19 October 2015 we carried out our own case review of the clinical records for 10 inpatients of Langley Green as part of our follow-up review. Seven of this sample were or had been detained under sections 2 or 3 of the Mental Health Act during their admission.

Langley Green Hospital uses a paper record system and all records are held in individual files. All seven of the files we reviewed had clear sections for Mental Health Act documentation. All seven of the records contained the appropriate papers in the appropriate sections and all contained copies of the original section papers, including all professional reports.

Six of the seven patients were recorded as receiving and understanding their rights under section 132 of the act. The remaining patient has been given his rights, but was considered not to have full capacity to understand them. A new date to repeat his rights had yet to be entered.

5.5 Local checks

Langley Green has introduced two methods of checking Mental Health Act documentation:

- a weekly ward checklist for Mental Health Act documentation to be completed by the wards; and
- a section of the *Review of revised MDT clinical review paperwork* which looks at Mental Health Act paperwork.

The weekly ward checklist for Mental Health Act documentation is a pro-forma checklist that is completed by all wards at the weekend and submitted to the ward manager. Any required actions are then reviewed by the ward's weekly multidisciplinary meeting about the patients' care. The checklist must be completed by a qualified nurse who works on the ward.

Both reports of the Care Quality Commission Mental Health Act monitoring visits noted the use of the weekly checklist for Mental Health Act documentation and commented that their use was considered to be "good practice".

The *Review of revised MDT clinical review paperwork* is a pro-forma checklist of eight aspects of clinical records. Details of the review can be found in appendix C. The review checks if notes comply with local *Standards and process for MDT professionals' meeting and clinical reviews* (appendix D).

In the review, a patient's Mental Health Act paperwork is RAG rated against two criteria (i.e. each patient has two possible ratings). The two criteria are that:

- Mental Health Act documentation and the giving of rights to the patient under section 132 of the Mental Health Act is documented correctly; and
- a capacity assessment has been completed and documented correctly.

In its evidence, the trust sent the review of the 19 August 2015 for 20 patients across all wards. 10 patients were detained under section 2 or section 3 of the Mental Health Act.

Of the possible 20 RAG ratings for the mental health act, four were rated red. Two of these were due to rights not being properly recorded and two were because capacity assessments had not been properly documented. The report showed no concerns with staff understanding the act.

We did have a concern about a rating for an informal patient, we discuss this in section 7 where we review progress on Recommendation 3.

5.6 Findings

F4 Verita's case notes analysis for this review, the Care Quality Commission's reviews and the trust's local reviews indicate that staff understand the use of sections 2 and 3 of the Mental Health Act and found no major concerns with administration of the act.

5.7 Conclusion

Recommendation 1 of the independent investigation (the trust should ensure that all staff understand the Mental Health Act, in particular in respect of the criteria for the use of sections 2 and 3) is in the process of being implemented.

6 Implementation of recommendation 2

The trust should further review the AWOL [absent without leave]/missing person's policy in conjunction with Sussex Police and should ensure that staff in both organisations understand its operation.

The independent homicide investigation undertaken by Verita in July 2014 found confusion between the police and the trust about the management of patients who were missing from care or absent without leave. The terms 'missing from care' and 'absent without leave' are significantly different, as the following extract from the original Verita independent homicide investigation shows:

"The term 'AWOL' is specifically used in the Mental Health Act code of practice to apply to detained patients. Staff use this term in respect of informal patients. This is important because it has legal implications and can lead to misunderstandings with the police. The trust policy uses the term 'AWOL' for detained patients and 'missing' for informal patients. The police use the terms 'missing' and 'absent' rather than 'AWOL', leaving scope for confusion."

The recommendation aims to reduce this confusion between the police and ward staff.

To assure actions against this recommendation we:

- reviewed the trust's absent without leave policy ratified on 28 November 2014;
- interviewed the Mental Health Liaison Officer for Sussex Police who liaises with Langley Green Hospital; and
- reviewed the case notes for incidents.

6.1 Absent without leave policy

The recommendation required the two organisations to work together to produce a policy that they could both use.

The independent homicide investigation report was published in July 2014. The Mental Health Liaison Officer for Sussex Police told us that the work on a joint policy had already commenced at the time of publication.

The policy was developed by the following:

- Head of Practice Quality, Sussex Partnership NHS Foundation Trust;
- Head of Social Care – Specialist Services, Sussex Partnership NHS Foundation Trust;
- Mental Health Liaison Officer, Sussex Police;
- Director of Patient Safety and Nursing Standards, Sussex Partnership NHS Foundation Trust; and

- Nurse Consultant for Acute Care, Sussex Partnership NHS Foundation Trust.

The result was a multiagency policy outlining the definitions of 'missing from care' and 'AWOL' as applied by both police and the trust and the actions from both services when patients abscond. The policy is trust wide.

The policy was ratified by the trusts Policy and Professional Practice Forum on 28 November 2014 and has been in operation since then. The policy is due for review by all services in November 2017.

We were given a copy of the policy. The policy includes a summary and definitions of the different terms used by both police and the trust and procedures and responsibilities for both services in the event of detained patients going AWOL. The appendices of the policy also contain a local search procedure checklist for Langley Green Hospital that includes when and how to contact the police.

6.2 Monitoring of the policy and relationship between the two services

Both the policy and its use are monitored in the trust-wide monthly Mental Health Act Monitoring Meeting, which is chaired by the trust's Head of Social Care – Specialist Services. The police are represented at this meeting.

The Mental Health Liaison Officer for Sussex Police told us that the police and the trust have a good relationship at present. She told us the Chief Executive Officer for Sussex Partnership NHS Foundation Trust and the Chief Constable of Sussex Police meet regularly and have a good working relationship. She also told us that she had a good relationship with trust personnel, and in particular the present modern matron of Langley Green Hospital. She said that she and the modern matron would contact each other by phone or email about any issues, but also for mutual support and advice. This was confirmed by the modern matron in a separate interview.

We asked the Mental Health Liaison Officer for Sussex Police if there had been any issues with the trust complying with the policy or incidents where informal patients had gone missing from care and come to harm. She said the multi-agency policy was carried out efficiently from the police's point of view and that trust staff were giving the police better information when reporting incidents. She was not aware of any incidents where informal patients had come to harm since the introduction of the new policy.

6.3 Case notes review

During our case notes review we noted that two of the 10 patients had been 'absent without leave' during their admissions. The subsequent progress notes clearly indicated what actions had been taken to manage these incidents and the actions by both trust staff and the police were in compliance with the new policy.

F5 Sussex Partnership NHS Trust and Sussex Police have developed a joint absent without leave/missing person's policy.

F6 The police and the trust monitor the use of the absent without leave/missing person's policy in the monthly Mental Health Act Monitoring Meeting.

6.4 Conclusion

Recommendation 2 of the independent homicide investigation (the trust should further review the AWOL [Absent without leave]/missing person's policy in conjunction with Sussex Police and should ensure that staff in both organisations understand its operation) has been implemented.

There is evidence of a good working relationship between the police and Langley Green Hospital and regular review of staff adherence to the policy.

7 Implementation of recommendation 3

The trust should assure itself that informal patients are not detained illegally.

Informal patients have the right to leave hospital if they wish and cannot be coerced to remain on the ward. To deny this right is an unlawful deprivation of the liberty of patients who are not subject to legal powers of detention under the Mental Health Act. This is referred to as 'de facto detention'. The Verita independent homicide investigation found instances of de facto detention.

The Care Quality Commission has described ways in which patients may be detained by de facto:

“We found evidence that patients who were not formally detained may be prevented from leaving. Measures of this included whether informal patients said that they were unable to leave the ward, where staff reported that they would automatically use holding powers to stop an informal patient leaving, or where staff were uncertain which patients were informal and which were detained.”⁷

In monitoring this recommendation we:

- reviewed the reports of the Care Quality Commission’s Mental Health Act monitoring visits;
- carried out a ward visit to check signage for informal patients; and
- reviewed local arrangements for checking the rights of informal patients.

7.1 CQC visits and signage for informal patients

The reports of the two Care Quality Commission Mental Health Act monitoring visits noted that the wards were locked, but that there was clear signage for informal patients informing them of their right to leave the ward if they wished.

As part of our review we visited a ward and saw that signage was in place that informed informal patients of their right to leave the hospital.

7.2 Case notes review

We also reviewed the documentation of the three informal patients in our case review. We found that one patient had asked for and accessed the Independent Mental Health Advocacy Service, which we regarded as good practice as this service is often perceived as being only for patients detailed under the Mental Health Act.

⁷ [See page 41 Care Quality Commission: *Monitoring the Mental Health Act in 2012/13*](#)

The notes clearly recorded the informal status of all three patients, and we found no evidence of coercion for them to remain on the ward.

7.3 Local checks

As mentioned earlier the *Review of revised MDT clinical review paperwork* includes a section monitoring use of the Mental Health Act. We had concerns about one comment about a patient on Jade Ward which says:

“Informal, but it is consistently documented the patient is to be placed on [section] 5 (2) [of the Mental Health Act] if they attempt to leave.”

The trust had given this patient's notes a 'green' rating but, as recorded, this is a de facto detention as defined by the Care Quality Commission as staff are reporting that they would automatically use holding powers to stop the patient leaving. The review also says an assessment of this patient's capacity had not been done.

The trust's review should have marked this finding as 'red'. Steps should have been taken to clarify the patient's status and management with the ward team and remove the de facto detention.

7.4 Finding

F7 This review found an informal patient was de facto detained as defined by the Care Quality Commission.

F8 The trust's audit of revised multidisciplinary clinical review paperwork had not recognised the de facto detention of an informal patient.

7.5 Recommendation

R2 The multidisciplinary meetings on the ward should review all informal patient records to ensure that none are de facto detained as defined by the Care Quality Commission.

R3 If an informal patient is found to be de facto detained, their care should be reviewed and a clear record made of their status under the Mental Health Act. This should be communicated to the patient in writing.

R4 The monitoring of informal patient records should be carried out by the Mental Health Act administrators.

7.6 Conclusion

Recommendation 3 of the independent homicide investigation (the trust should assure itself that informal patients are not detained illegally) has not been implemented.

8 Implementation of recommendation 4

The trust should issue guidance to staff on the need to ensure that all risks are clearly set out in the risk management plan and communicated to staff. The trust should also ensure that mechanisms are in place to make sure this happens.

National policy says risk assessment and risk management should be at the heart of effective mental health practice. Trust policy at the time of the incident said that all service users should have a risk assessment completed as part of the assessment and any risks or issues around safety identified should be incorporated into the service user's care plan.

The Verita independent investigation found that risk assessments and risk management plans for Mr M were confusing and sometimes illegible.

To assure actions against this recommendation we:

- reviewed guidance to staff for conducting ward reviews of patients;
- reviewed the monitoring of risk management in Langley Green Hospital; and
- carried out a case review of a sample of 10 patients across all wards.

8.1 Guidance to staff in Langley Green Hospital

Senior staff told us that patients were risk assessed as part of the admission process. After admission, patients were reviewed weekly in the multidisciplinary professionals' meeting when the care for the week was decided.

The meeting should conform to the *Standards and processes for MDT professionals' meeting and clinical reviews* (appendix D). These standards say that risks should be identified and recorded at these meetings and management plans based on the current clinical presentation formulated.

Although inpatient services in the trust, including Langley Green Hospital, use handwritten paper notes, staff can use the template of the trust's electronic recording system (which is called eCPA) to produce printed versions of reports.

Following the weekly multidisciplinary professionals' meeting, and patient clinical review, the *Standards and processes for MDT professionals' meeting and clinical reviews* say the eCPA should to be updated and a copy printed out and placed in the paper notes. This means that the records are now printed out, whereas at the time of the incident they were hand written.

The Clinical Director for Langley Green provided a summary of the update session held to inform staff of the standards. Training sessions for the ward consultant psychiatrists, ward managers and psychologists were held in December 2104 and March and April 2015. Following this, 23 of the wards qualified nurses attended update sessions from April to June 2015.

8.2 Monitoring of compliance

The standard of paperwork is monitored through the *Review of revised MDT clinical review paperwork*. This is a trust developed set of standards. There is no specific part of the review that monitors risk, but it is clear in the comments under 'Overall alignment and focus of care' that risk management is considered.

Our review of the trust's internal risk monitoring audit carried out in August 2105 raised concerns about three patients. Two of these were RAG rated as 'amber', but resulting care plans had not been updated. One patient on Coral Ward was rated as 'red' as the "care plan is very poor and does not clearly state current risks".

The review that we have seen in August was fed back to staff through the weekly project plan meeting and a written summary sent to ward managers in September. The summary said: "The overall alignment of care documentation has improved and is generally good."

8.3 Case note review

On 19 October 2015 we examined 10 sets of patients' notes to see if the risk assessment and management met with the *Standards and processes for MDT professionals' meeting and clinical reviews*.

We found that nine sets of notes fully complied with the standards. These notes had updated eCPA print outs that clearly recorded risk assessment and management. The notes also included sections for the recording of the patient's view of their care and management.

We did have a concern about the standard of care planning in the clinical notes. While all 10 patients had care plans they tended to be written in professional language and cover multiple needs. There were also set phrases used in a number of care plans that indicated they were not individualised.

There were, however, exceptions. One care plan had been printed out using the standard pro-forma sheet, but the patient had made their own comments and amendments before signing. We regarded this as good practice.

One care plan was written in a completely different format to the standard care plan sheet and was of very good quality. However, this was in the records that did not meet the standards for multidisciplinary meetings as the patient had been risk assessed on admission and, while there was an individualised care plan, there was no record of a multidisciplinary discussion of the patient's care.

8.4 Findings

F9 The trust has issued guidance to staff on conducting weekly patient reviews. This guidance states that risks and mental health presentation should be reviewed.

F10 The trust has a mechanism to monitor the overall guidance, including the recording and managing of risk.

F11 An analysis of case notes carried out for this review indicated the guidance was followed for nine of the 10 cases examined.

8.5 Conclusion

Recommendation 4 of the independent homicide investigation (the trust should issue guidance to staff on the need to ensure that risks are clearly set out in the risk management plan and communicated to staff) has been implemented and there are mechanisms in place to make sure this happens.

9 Implementation of recommendation 5

The trust should establish a process with the police, probation and prison services for rapidly obtaining information about forensic histories and index offences where patients are deemed a risk to others.

The original homicide investigations found that there was no policy or process for obtaining information about index offences or for seeking information about forensic histories outside of the Multi Agency Public Protection Arrangements (MAPPA).

In monitoring this recommendation we:

- interviewed police from the Sussex Police Mental Health Liaison office for Langley Green Hospital;
- carried out a group interview with the Consultant Psychiatrist and Ward Manager of Amber Psychiatric Intensive Care Unit and the Consultant Forensic Psychiatrist who is link consultant for Langley Green Hospital; and
- reviewed documentary evidence provided by the trust against this recommendation.

9.1 Access to the Police National Computer records and MAPPA

The Police Liaison Office informed us that there was now a system in place for clinical staff to request information from the Police National Computer. The police told us that they have a duty to protect the information on their files and that trust staff do not have direct access to this information. However, staff can ask if they have any specific concerns about an individual and the police can reply to that request. The example we were given was a trust staff member contacting the police to ask “should we have any concerns that this person may be a danger to others”: the police will provide information about any record of harm to others, but not convictions or cautions outside of the question.

We also received a description of the process for trust staff to request such information. This showed that the trust’s Head of Social Care provided a single point of contact for requests. Clinicians would contact the Head of Social Care via a secure email to request information and this would then be sent to Sussex Police’s ViSOR (Violent and Sex Offenders Register) Officer. This officer would respond to the Head of Social Care via the secure email giving relevant information or say that there was no known information. This would be retained by the Head of Social Care and the ward would be informed by telephone what to record in the clinical notes.

It should be noted that ViSOR provides a central store for up-to-date information about offenders that is accessed and updated by the police, the prison service and the probation service⁸.

The Head of Social Care is also the trust's MAPPA lead. MAPPA is designed to protect the public by reducing the risk of further serious violent or sexual offending from people previously convicted of such assaults. The arrangements require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership. The MAPPA panel members have access to the information on the ViSOR/Police National Computer database via the police.

9.2 Forensic clinics in Langley Green Hospital

One finding of Horsham CCG's review carried out by Verita in December 2014 was that a high number of patients had been referred to forensic services for assessment. The December review reported that:

- eight patients [in Langley Green Hospital in December 2014] (13 per cent of the total) were waiting for or had received a forensic assessment; and
- of these, four patients had been assessed as needing specialist care and were waiting either for an assessment by Cygnet Healthcare (a private care provider) or for a place in a forensic or private care provider.

We were told by the link Forensic Consultant that the eight patents referred to in the December report were subsequently reviewed and that all had, in fact, been assessed by the trust's forensic services at the time.

Since February 2015 the forensic services and staff at Langley Green Hospital have developed forensic liaison clinics to enable rapid assessment and input from the trust's forensic service. The clinics run when there is a need (i.e. when there are referrals to the forensic service from Langley Green wards). The clinics are coordinated by the Ward Manager of Amber Ward, the psychiatric intensive care ward for Langley Green Hospital.

The clinics are a forum for ward staff to discuss patients' needs and get advice on management from the link Forensic Consultant. Patients are not seen during this discussion. If indicated, however, a face-to-face assessment by the forensic service will be arranged.

At the time of this review there have been three forensic clinics that have discussed 20 individual patients. The link Forensic Consultant told us that at least five patients had been formally assessed by the forensic service as a result of the discussions in the clinics.

⁸ See [section 8 of MAPPA Guidance 2012 from National MAPPA Team. National Offender Management Service Offender Management and Public Protection Group](#)

We were given access to the notes of two of the forensic clinics that had reviewed 11 patients. There was clear evidence in the notes of staff requesting further information from other agencies, including one instance of requesting information from the Police National Computer.

9.3 Findings

F12 There is a clear process for ward staff to access relevant information from ViSOR data on the Police National Computer which is updated by the police, probation and prison services.

F13 There is evidence that staff request information for patient risk assessments from the Police national Computer.

F14 The newly introduced forensic clinics to support and advise ward staff are an example of good practice.

9.4 Conclusion

Recommendation 5 of the independent homicide investigation (the trust should establish a process with the police, probation and prison services for rapidly obtaining information about forensic histories and index offences where patients are deemed a risk to others) has been implemented.

10 Implementation of recommendation 6

The trust should ensure that staff routinely involve families in discussions and decisions about a patient's care, in line with trust policy.

The independent homicide investigation found that Mr M's mother informed trust staff of vital information about his violence and paranoia. This was not recorded or taken into account in any assessments on the ward. There was no evidence that Mr M did not want his family involved in his care and the trust's policy is clear that such information should have been used in risk assessments and risk management plans.

In monitoring this recommendation we:

- reviewed 10 clinical records for evidence of carer involvement; and
- interviewed the Langley Green Hospitals lead for the Triangle of Care.

The trusts *Standards and process for MDT professionals' meeting and clinical reviews* (appendix D) states that:

“Carers wherever possible will be involved in the patient's care and their observations and comments will contribute to the care planning process.”

However, this standard is not monitored in the *Review of revised MDT clinical review paperwork* (appendix C).

10.1 Evidence of carer involvement

The updated action plan sent by the trust says that the revised multidisciplinary clinical review meeting includes a section for recording information from carers. There is no evidence that this is monitored.

In the 10 clinical records that we reviewed, three recorded that carers had attended a multidisciplinary clinical review meeting. There were recorded difficulties between the patients and their carer in two other records, and one carer was also receiving treatment from the trust and was not well enough to support the patient involved. One patient was a foreign national and alone in the UK but her family had been contacted.

Although the remaining three sets of notes included details of the patient's family, there was no information about any attempts by ward staff to contact them or that they had visited the ward. All three had an entry in the multidisciplinary clinical review meeting notes that the carer or family should be offered support if they attend the ward, but the entry had no action and had been repeated over several meetings.

Although there was some evidence of consideration of carer involvement and actual involvement, this is not consistent in all cases.

10.2 Triangle of Care

The Triangle of Care is a guide to the strategic involvement of carers and families in patient care. Launched in July 2010, it was collaboratively developed by the Carers Trust and the National Mental Health Development Unit.

The Triangle of Care identifies six key standards for carer inclusion:

1. carers are identified at first contact or as soon as possible;
2. staff are 'carer aware' and trained in carer engagement strategies;
3. a policy and practice protocol is in place for confidentiality and information sharing with carers;
4. there are defined posts responsible for carers in place;
5. a carer introduction pack to the service and staff is available, with a relevant range of information across the care pathway; and
6. a range of carer support services is available, including support, career assessment and family interventions.

As part of our review we interviewed the occupational therapist who is the lead for Triangle of Care within Langley Green Hospital.

He informed us that the present emphasis was on achieving Standard 2 and staff being "carer aware". To facilitate this a rolling programme of staff training has been put in place. This training has dedicated sessions where a carer talks to participants on their experiences of being a carer.

In the year to September 2015, there have been three training sessions attended by a total of 25 staff. We were told the sessions were well received and that more were planned.

We were also given copies of the monthly Langley Green newsletter launched in June 2015. The July edition contained information on Triangle of Care training for staff and the reintroduction of a carers support group for the hospital.

The Triangle of Care guidance includes a self-assessment tool to monitor progress against the six key standards. This has not been used at Langley Green Hospital.

During our ward visit we noted that carer information leaflets were available throughout the hospital at various points and that each ward had a sign on the door providing the name and a contact number for the modern matron and ward manager. The modern matron informed us that carers had contacted her on the number provided.

10.3 Findings

F15 The trust does not have a mechanism to monitor the inclusion of carers in patient care.

F16 Langley Green Hospital is implementing the Triangle of Care guidance and the inclusion of carers in training is an example of good practice.

10.4 Recommendation

R5 The leadership team should devise a mechanism to monitor the inclusion of carers in patient care.

10.5 Conclusion

Recommendation 6 of the independent homicide investigation (the trust should ensure that staff routinely involve families in discussions and decisions about a patient's care in line with trust policy) is in the process of being implemented.

11 Physical health checks for patients and staffing

Further checks on patient care carried out by the trust and the Care Quality Commission following the Verita independent homicide investigation highlighted issues of concern. The trust has responded to these concerns and asked that this review provide an independent opinion on actions taken and planned to address them.

Two areas were identified for an independent opinion:

- physical health checks for patients; and
- staffing the wards.

11.1 Physical health checks

11.1.1 Main physical health screening tools used across all wards

On admission patients are given a full physical examination by medical staff. Once on the ward, staff monitor patients' physical health until they are discharged.

As part of this monitoring the trust uses the 'Malnutrition Universal Screening Tool' ('MUST'). The MUST effectively monitors a patient's general level of nutrition calculating their body mass index and monitoring weight loss over time.

In addition to MUST, and in response to the concerns about the physical health monitoring of patients, the leadership team at Langley Green Hospital introduced the Modified Early Warning Score (MEWS).

MEWS is a nationally recognised form of 'track and trigger' scoring system. The triggers are based on routine observations and are sensitive enough to detect subtle changes in physical health that are reflected in a change of score should the patient be improving or deteriorating.

MEWS relies on the routine recording and charting of physical observations or vital signs of the patient. These observations include:

- pulse;
- respiratory rate;
- temperature;
- blood pressure; and
- consciousness.

The MEWS also contains a neurological observation scale, a daily fluids chart, a blood sugar recording chart and a weight chart.

The frequency of monitoring is increased if abnormality is noticed or if the patient has rapid tranquilisation⁹ or an adverse physical events such as a fall or a seizure.

Both MUST and MEWS monitoring systems have plans for action if readings are outside the norm. A crucial aspect of this is to review physical health in the multidisciplinary clinical review.

11.1.2 *Monitoring of physical health screening*

Physical health is monitored through the *Review of revised MDT clinical review paperwork*. In addition wards carry out their own audits of MEWS using a protocol designed by the trust's audit department. We received copies of completed audits for one week carried out by individual wards.

We did have some concerns that wards had different interpretations of the ratings for the MEWS audit. In the audits we have seen some wards rated some criteria as 'not applicable' whereas others gave them a rating. We discussed this with individual ward managers and they shared our concerns.

The *Review of revised MDT clinical review paperwork* gave a more generic rating for physical health and was not as detailed on implementation of the MEWS scales as the ward audit. The review also notes if any concerns about physical health have been raised in the weekly clinical review meeting. The review we saw for the 19 August 2015 gave two patients 'red' ratings as their MEWS scores were not up to date.

11.1.3 *Findings*

The introduction of the MEWS is a positive intervention. The evidence that we have seen indicates that it is being used on the wards, although we have concerns about whether the wards are interpreting the audit standards in the same way.

The MUST tool is also a nationally recognised screening tool although it is focused primarily on body mass index and fluctuations in weight. While at present both tools are in use, the audit and monitoring indicate that MEWS is the primary tool as it covers a wider range of physical health indicators.

11.2 Staffing

Langley Green Hospital has experienced a number of staff changes since the incident in 2012. We were sent a number of documents outlining the low staffing levels and proposals to address this. We have no reason to question these documents and have accepted that they are an accurate record of the issues.

⁹ Rapid tranquilisation is a phrase that means a patient has been sedated due to extremely agitated behaviour.

11.2.1 Langley Green proposal to address nursing vacancies

An options paper for recruitment needs written by the Langley Green Hospital General Manager in August 2015 showed that 40 per cent of band 2 to 5 posts across all wards were vacant. In terms of actual numbers, this meant the hospital needed to recruit 19.85 whole time equivalent band 5 staff¹⁰ and 19.90 whole time equivalent band 2 staff¹¹ to become fully established in these bandings.

The paper also notes that traditional routes for recruitment have not shown good results. This traditional route is advertising and interviewing through the NHS Jobs website.

In response to this, Langley Green Hospital has recruited a full-time recruitment coordinator to address the ongoing staffing needs.

During this review we interviewed the senior staff and queried if the recruitment needs were confined to junior staff. We were informed that the medical staffing of the hospital was now adequate and that the major concern was for the ward nursing staff, both qualified and unqualified.

The options paper also proposes actions to address the shortfall in addition to traditional nurse recruiting. These are:

- each ward offering an apprenticeship¹² position;
- for psychologists and occupational therapists who have traditionally worked in departments outside of the wards to be attached to wards and included in the ward rota¹³; and
- the introduction of graduate mental health workers onto each ward. These workers would have an appropriate relevant degree (such as psychology) and experience in working within mental health. The proposal we have seen suggests employing these workers as a band 5 equivalent.

The options paper discusses the implications of the proposed introduction of graduate mental health workers into the existing nursing workforce and includes a SWOT (strengths, weakness, opportunities and threats) analysis.

In this, the strengths and opportunities were that a reduction in the vacancies would give more stability to the nursing workforce and allow the nursing staff to focus on specific nursing tasks including medication management and administration of the Mental Health Act. The weakness and threat of the proposal is that any new model

¹⁰A newly qualified staff nurse is a band 5.

¹¹ An inexperienced health care assistant is a band 2.

¹² Apprenticeships are a combination of on-the-job training and classroom teaching in which workers new to the workforce learn the practical and theoretical aspects of an occupation.

¹³ During the drafting of this report we were informed that this proposal had been amended and the change is now only proposed for occupational therapists.

of workforce can lead to confusion as to “who can do what” and governance of the new roles which will be outside of normal professional regulation as well as create discontent among existing health care support workers and newly qualified band 5 nurses.

The actions above will not affect a total reduction in the vacancies and the trust will need to continue to try and attract qualified nursing staff.

During the drafting of this report we were informed that the graduate worker post would now be offered as a band 4 post.

11.3 Findings

We were asked to consider any risks that may be evident in the new recruitment strategy as the trust considers these proposals. As we have seen earlier, changes in staff have left the existing workforce under pressure and resulted in the trust having to ‘catch up’ with issues such as mental health training.

However, taken separately, none of the actions above are entirely new. Apprenticeships are a recognised means to introduce new workers to a profession¹⁴, and the realignment of psychology and occupational therapy has been done in other areas and indeed is the norm in many community teams.

The creation of graduate workers has also been introduced in other clinical areas. Primary health care has employed graduate mental health workers to staff its psychological therapy programmes and other mental health trusts have introduced graduate workers as a means to address vacancies. An example of this is the Graduate Mental Health worker scheme introduced by London mental health trusts in conjunction with Middlesex University. This scheme recruits the graduates onto a Post Graduate Diploma in Mental Health Practice in the university while also employing them within the trusts. During the course graduates spend 60 per cent of their time in practice and 40 per cent in the university. After the course, the trusts are in a position to retain the graduates in their workforce.

The caveat to this is that these workforce changes, while not new, have yet to stand the test of time. Apprenticeships were first launched in 2009 and, are now highlighted by government as a means to introduce new workers but graduate worker schemes are less established. For example, the Middlesex and North London trust graduate scheme started in 2011 and is now only in its fourth year of operation.

While we feel the options paper and particularly the SWOT analysis accurately summarises the risks and benefits of the present Langley Green Hospital recruitment

¹⁴ Healthcare apprenticeships were first launched nationally in 2009 and details of present schemes, including mental health, can be found on the [government Skills Funding Agency website](#)

strategy, we would recommend the trust seeks advice from providers who have introduced similar programmes as well as national bodies such Skills for Health¹⁵ and the Skills Funding Agency as to the best way to monitor workforce changes and develop the best solution for Langley Green Hospital.

Finally, while we have not examined the issue of retention, it is as important that the trust make every effort to retain existing staff who are introducing many of the changes evident in this report. In addition, the trust should not abandon the traditional methods of recruitment, and continue to use these methods to try and attract more experienced qualified staff.

¹⁵ Skills for Health are a nationally recognised organisation that, among other services, offer advice on workforce planning and staff recruitment and retention

Verita Independent homicide investigation: part 2 thematic review recommendations

The recommendations relating to part 2 of the independent homicide investigation carried out by Verita are given below.

R7 Multidisciplinary, integrated care and risk management “at a glance” plans should be implemented immediately pending the introduction of an IT system.

R8 All current active files should be reviewed and put in good order. The format of files should be reviewed and regular audits of files should take place until an IT system is in place.

R9 Pending the introduction of a ward-based IT system, a temporary procedure should be introduced which ensures that community and ward notes are accessed as part of one process.

R10 The trust should agree how and when a new integrated community and ward IT system will be introduced and should tell staff about it.

The thematic review of the independent homicide investigation showed that the clinical record keeping at the time of the incident in 2012 was not fit for purpose. The clinical record files were large, chaotic and specific clinical information was hard to find. The state of the records was considered a considerable risk as, even if a record had been appropriately entered, it was debatable if staff could find it.

These findings were confirmed by the Care Quality Commission inspections and the CCG inspection of December 2014.

Under the new leadership team, staff have worked hard to improve record keeping. The Care Quality Commission’s follow-up report of February 2105 indicates that it was no longer concerned about the state of the clinical notes.

During the course of this review we conducted a review of 10 sets of notes for patients across all four wards. This case review found considerable improvement in the clinical records. In summary, these improvements are set out below.

1. Notes are divided into clearly marked sections.
2. Notes include sections for Mental Health Act documentation, progress notes, multidisciplinary reviews and care plans.
3. The trust has introduced a ‘patient tracker’ sheet for patients who are transferred between wards. This is kept at the front of the notes.
4. The trust has also introduced a local ward audit of the notes with recommendations for improvement. This is also kept at the front of the notes.

We have seen evidence of individual supervisor records for staff that show feedback to individual staff with recommendations for improvement.

5. The *Review of revised MDT clinical review paperwork* also audits quality of the notes and highlights any missing patient trackers or incomplete ward audits.
6. Notes that become too large are divided and older notes stored in a separate file. A summary of these records is retained in the working notes.
7. Multidisciplinary meetings and clinical reviews are now uploaded onto the eCPA system and printed out. Previously these notes would have been hand written and sometimes difficult to read.

Senior staff told us that the trust is planning to introduce Care Notes, an electronic records system, across the trust in 2016. We interviewed a ward manager at Langley Green who is part of the team advising on the introduction of Care Notes.

As a consequence of these developments, we consider that the recommendations under part 2 of the independent homicide investigation have either been completed or no longer apply.

List of documents provided by the trust

Action plans

- Action plan following Mr M and Mr P investigation: updated September 2015
- Langley Green Hospital: acute quality and safety project plan (last Updated October 2015)

Evidence against action plans provided by the trust

Recommendation 1 evidence list

- Trust policy for assessment of persons under sections 135 and 136 of the Mental Health Act
- Trust consent to treatment policy
- Trust policy on conveyance of patients - section 6 Mental Health Act
- Trust policy on deprivation of liberty standards (DOLS) policy
- Trust policy: Leave of absence - section 17 Mental Health Act
- Trust policy: Mental Capacity Act 2005
- Trust policy: Patient records - mental health advocates access policy
- Trust policy: Sussex Partnership's section 117 practice guidance
- Trust policy: Mental Health Act - Section 5 - holding powers
- Trust policy: Supervised community treatment policy
- Trust policy: Victims' rights under the Domestic Violence, Crime and Victims Act 2004 policy
- Trust policy Visiting detained patients in hospital
- Trust policy Information for detained patients
- Care Quality Commission Mental Health Act monitoring visit 17 Aug 2015
- Care Quality Commission Mental Health Act monitoring visit 11 May 2015
- Amber Ward weekly checklists

Recommendation 2 evidence list

- Absent without leave policy
- Absent without leave policy timeline for patient - 11 Sept 2015
- Matron update on relationship with local police liaison officer

Recommendation 3 evidence list

- Amber Ward mental health audits – September 2105
- Letter re invalid detention of patient

Recommendation 4 evidence list

- Ward managers' audit summary
- *Review of revised MDT clinical review paperwork*, 19 Aug 2015
- Multidisciplinary update sessions for staff following revision of MDT paperwork
- Ward handover audit - Amber ward
- Ward handover audit - Coral ward
- Ward handover audit - Jade ward
- Ward handover audit - Opal ward
- Anonymised copy of staff member supervision record

- Internal paper produced to introduce revised multidisciplinary team process

Recommendation 5 evidence list

- Overview of forensic liaison process
- Forensic liaison clinic minutes, 26 Mar 2015
- Description of Police National Computer process from the Head of Social Care

Recommendation 6 evidence list

- The multidisciplinary clinical review eCPA template

Information given during the review.

- Summary of Langley Green Hospital Resisted Nurses training schedule (Mental Health Act and Clinical Risk training)
- Modified Early Warning Score (MEWS) template
- Ward Audits of Modified Early Warning Score (MEWS)
- Sussex Partnership NHS Foundation Trust; Options Paper –“recruitment needs within Langley Green Hospital” 25 September 2015
- Sussex Partnership NHS Foundation Trust: “Safe Staffing Appendix”; Board of Directors papers for meeting of the 30 September 2015

[UNEDITED TRUST DOCUMENT]

Review of revised MDT clinical review paperwork

The *Langley Green Hospital: acute quality and safety project plan* charts how changes to clinical record keeping were introduced following criticism in the Care Quality Commission review and the original independent homicide investigation carried out by Verita.

Between December 2014 and June 2105 record keeping was audited and new standards introduced.

These standards are monitored through the *Review of revised MDT Clinical Review paperwork*. This is an audit of five sets of clinical records by an occupational therapist and nurse consultant.

Findings from the review are fed back to the Langley Green Hospital Acute Quality and Safety Project Plan monitoring group which in turn feeds back to the ward.

The review examines eight aspects of the clinical records. The review is RAG rated with comments added as to why the rating was applied.

1. Evidence that the revised multidisciplinary form is in use.
2. Evidence that the weekly patient review has taken place and includes
 - a. a multidisciplinary professional meeting
 - b. a clinical review of patients care
 - c. a completed summary of clinical management.
3. Evidence of discharge planning.
4. Evidence of physical health including MEWS.
5. Review of Mental Health Act paperwork.
6. Quality of care plan and link to multidisciplinary summary in 2c above.
7. Evidence that handover sheet/ward transfer tracker is in use,
8. Overall alignment and focus of care.

[UNEDITED TRUST DOCUMENT]

Standards and process for MDT professionals' meeting and clinical reviews

General standards

1. Each week the ward will hold an MDT professionals' planning meeting. The purpose of this will be to discuss each patient and summarise the past week and to plan the care for the week ahead.
2. Each patient will be invited to be involved in a MDT clinical review at least weekly, as a way of engaging them in their care planning and treatment.
3. Carers wherever possible will be involved in the patient's care and their observations and comments will contribute to the care planning process.
4. To enable effective communication within the inpatient team as well as between the ward team and other professionals involved in the patient's care, the standardised MDT Clinical Review must be used.

Professionals' planning meeting guidance

The three key tasks of the planning meeting are to:

1. review the risks and mental health presentation – based on all the information available to the MDT;
2. develop an MDT formulation of the current clinical presentation;
3. plan the care for the week ahead – involve the patient in care planning, and invite and welcome input from carers or family.

Additionally

1. Ensure appropriate tasks are completed in a timely fashion.
2. Provide a consistent view of care and treatment.
3. To ensure the clinical review is informed by the MDT formulation.
4. To timetable the MDT clinical reviews for the week so patients and carers can be informed and appropriate professionals can be invited.

Process

1. Part 1 will be completed during the professionals' meeting.
 - a. Following the professionals' meeting, the timetable will be displayed on the ward and patients/carers will be informed
2. Part 2 will be completed during the clinical review.
3. Following the MDT clinical review the document will be completed on the same day and will be signed by the nurse and senior medic.
4. On the same day, the MDT clinical review will then be uploaded onto eCPA with a copy filed in the ward paper notes.
5. MDT clinical review to be used to update the nursing care plan and to describe the nursing interventions to manage the current issues.