An independent thematic review of investigations into the care and treatment provided to service users who committed a homicide and to a victim of homicide by Sussex Partnership NHS Foundation Trust:

Extended executive summary

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Extended Executive Summary

1   Introduction

1.1   This report is the outcome of the thematic review commissioned by NHS England South and Sussex Partnership NHS Trust (the Trust). The report consists of this extended Executive Summary, the main report (volume 1) and supporting detail and evidence (volume 2). The full Terms of Reference for this review are included in Appendix A in volume 1.

1.2   This is a review of reports of 11 investigations into the care and treatment provided by the Trust to ten service users who became involved in serious incidents. These incidents took place between 2007 and 2015.

1.3   There were:
- ten serious incidents (two reports related to one serious incident)
- nine serious incidents (10 reports) are homicides[1]
- one service user was the victim of a homicide
- eight of the homicide investigations were independent (relating to seven homicides)
- two of the homicide investigations were internal.

1.4   When a homicide is committed by a person who is, or who has recently been, a user of mental health services, there must be an independent investigation into the care and treatment provided to that person by the mental health trust[2]. This is in addition to the internal review of care and treatment which is carried out by staff of the mental health trust who were not directly involved in the provision of care and treatment.

1.5   Throughout this report, the reader should be conscious of the limitations of the information provided. Fortunately, the number of homicides in a given year involving any one of the Trust's service users will be very small – in this case, ranging from none in 2013 and three in 2012. An increase or decrease of one homicide in a year can make it appear that there has been a large change in the figures and these figures should not be over interpreted for this reason.

1.6   The main report (Volume 1) is presented in three sections:

- Introduction and background.
- Findings.
- Recommendations.

1.7   Volume 2 contains detailed information about the methods used in the review; information about the review team members (which included a carer, as

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[1] Homicide is the killing of one human being by another. The cases included in this review were offences of murder: offences of manslaughter on the grounds of diminished responsibility.

[2] This is set out in HSG (94) 27 and NHS England *Serious Incident Framework* 2015.

requested by the Trust); and the evidence which supports the findings in Volume 1.

1.8 The Trust is one of the largest mental health trusts in England. It covers both rural and urban communities, with small ethnic minority populations in all except two areas – the city of Brighton and Hove, and Crawley (which includes Gatwick airport and much of its workforce).

1.9 The Trust implemented major changes to the way services were organised and new clinical leadership responsibilities were allocated in 2011/12 in order to improve the quality of care and treatment provided. These changes were in part in response to previous learning from reports.

2   Benchmarking

2.1 Based on national statistics[3], it can be predicted that approximately nine homicides would be committed by service users in a mental health trust serving a similar population to Sussex Partnership Trust in the same timeframe. This is in line with the number committed by service users of the Trust between 2010 and 2015.

2.2 Whilst remaining cautious about over interpreting the small numbers involved, this suggests that the Trust has a rate of homicides committed by service users which is not disproportionate to the population served.

2.3 Looking at the characteristics of the people who committed a homicide, key findings of the benchmarking exercise are:

- Compared to national information on patients who commit homicide, Trust patients in this sample who committed a homicide were:
    o exclusively male – nationally, perpetrators are about 15% female
    o exclusively 'White British' – 45 years of age or more – nationally, the most numerous group is between 25 and 44
    o as likely as the national picture to kill an acquaintance (only two killed a stranger)
    o as likely to use sharp instruments as the means of committing the homicide.

- Trust patients did not display the same risk factors as the national picture. They are:
    o more likely to comply with medication
    o more likely to attend appointments
    o misuse drugs and alcohol to a slightly lesser degree.

2.4 Nearly half this group of the Trust cases had been in long-term contact with the mental health services (i.e. 10 years or more) – some continuously and some who were in and out of contact as they moved around the country.

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[3] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness *Annual Report 2015: England, Northern Ireland, Scotland and Wales* July 2015. University of Manchester.

3 Recurring themes

3.1 Themes were defined as 'recurring' if they were identified in at least two investigation reports. The themes that we identified using this definition were as follows.

3.2 Escalating users to a proper level of expertise. Several of the reports showed that there could be delays either between GP referral and initial assessment by the Trust; or between initial assessment by the Trust and access to more specialist assessment (for example, forensic services). Organisational changes have led to shorter waiting times and access times to a number of specialist services have improved.

3.3 Risk assessment and risk management. In seven out of the nine cases of homicide, there was criticism of the risk assessment process and/or the design of the risk management plan. In several cases, the process was seen as inadequate or the risk posed was not recognised or was seriously underestimated.

3.4 Knowledge and use of the Mental Health Act. On several occasions in the investigation reports, Trust staff did not know the full extent of their legal powers when working with service users.

3.5 Systemic or professional problems identified. Several investigations reported that staff did not conform to local policies and/or national guidelines:

- Carers did not receive a carer's needs assessment.
- NICE guidelines for treatment and care of people with psychosis were not followed.
- Service users in long-term contact with the Trust had not been re-assessed for several years.

4 Emerging themes

4.1 The ten investigation reports were analysed for themes using the 'patient safety framework'[4]. The factors relate to: the 'patient'; 'individual (staff)'; 'task and technology'; 'communication'; 'team working'; the 'work environment'; 'organisational and management'; and 'institutional context'.

4.2 Patient and team factors feature in all the cases; task and technology and communication factors were the next most frequent categories; individual staff factors came next; work environment and organisational and management factors also featured; but institutional context factors were not identified in any of the cases.

4.3 These findings reflect the fact that this group of Trust service users had complex needs, often with long-established patterns of erratic behaviour.

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[4] Vincent C 2010 *Patient Safety* Chichester John Wiley 2nd Edition. This is a classification of factors which may contribute to a homicide or other serious incidents.

4.4 Not all of the factors were of equal levels of concern and the specific issue of some factors seems to have changed over time – for example, a change from 'no risk assessment' the rationale for the assessment not being provided. The continuous existence of some factors (such as individual staff and team factors) suggest that patterns of behaviour and practice have persisted over time.

5   The 'mind-set' of policies

5.1 Some Trust policies seem to focus on the service user as potential victim (of abuse, for example) rather than acknowledging that service users can also be perpetrators of abuse and violence.

5.2 The investigation reports include descriptions of incidents of violence and aggression that take place in the community but are not reported through the Trust's incident reporting system.

5.3 We recognise that, overall; people with mental health issues are more likely to be victims of abuse and violence than perpetrators. However, Trust policies need to reflect the reality that some service users will be perpetrators.

5.4 Policies should reflect this reality and thereby encourage a more questioning stance toward service users' behaviours. A more questioning approach may lead to better and more accurate risk assessments and risk management plans.

6   Adverse event indicators

6.1 The Terms of Reference required us to identify any 'adverse event indicators' which could be identified in those reports which considered the homicide to be either preventable or predictable.

6.2 The homicide was considered to be predictable or preventable in only two of the nine independent investigation reports. The main common factor in these reports was improvements required in risk assessment and risk management.

6.3 Risk assessment should be comprehensive in drawing together all relevant information – including that known to families and carers and then coming to a formulation. Risk assessment should be repeated every time the service users' circumstances change.

7   Analysis of recommendations in independent investigations.

7.1 In this section, we have analysed the recommendations the independent investigation reports made for service improvement and to reduce the likelihood of further homicides taking place. The recommendations have been classified using a model developed by Niche Patient Safety[5], who analysed recommendations made in investigations they carried out between 2014 and 2015. We have compared the classification created by Niche with the classification of the recommendations in the reports we have reviewed.

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[5] Niche Patient Safety (2015) *What Safety Lessons Can We Learn? Thematic Review of Independent Investigations*

7.2 The nine independent investigation reports we reviewed made a total of 48 recommendations while the Niche reports made 78 recommendations.

7.3 For the Trust investigation reports, the largest category was 'practice/risk' with 22 mentions out of 48. This includes recommendations on improving care plans and risk management, and ensuring that the Mental Health Act is used appropriately. In summary, these recommendations are asking the Trust to ensure that its clinical policies and procedures are being carried out on a systematic basis all the time with every service user.

7.4 The second largest category was 'organisational learning'. Recommendations in this category focus on audit of policies and procedures to ensure policies and procedures are effectively implemented.

7.5 'Contact with families' was the third most frequent category – this focusses on involving families and carers in the care and treatment of service users – this specifically mentions involving families in risk assessment and the Trust signing up to the 'Triangle of Care'.

7.6 The fourth largest category, 'Policy management', focusses on ensuring that the Trust's policies and procedures comply with national guidance and there are audits of the implementation and effectiveness of policies.

7.7 Other categories include 'training' (supervision, reflective practice); 'communication' (between primary care and the Trust, built into care pathways); and implementation of electronic care records.

7.8 Compared to the Niche recommendations, recommendations to the Trust were less likely to involve 'communication' and 'policy management' but more likely to include 'practice/risk'.

7.9 There are a number of published reviews of recommendations made over the past twenty years, which demonstrate a high degree of continuity with our findings. Auditing practice to ensure compliance with policies and procedures is a common theme. Training is often the recommendation to improve practice – for example in relation to risk assessment and formulation, care needs assessment and care planning.

7.10 The recommendations to the Trust reflect those made to other mental health trusts currently and to services historically. They focus on the basics of care and treatment, compliance with policies and procedures, and involvement of families.

8   Implementing action plans

8.1 We reviewed the action plans which the Trust services had written to implement the recommendations from the investigation reports. The reason was to assess the extent to which the actions had been implemented, using the NHS Litigation Authority's three levels. These levels evaluate whether there is policy evidence (Level 1); whether there is evidence that policy is being implemented in practice (Level 2); and whether there is evidence that performance is being embedded across the organisation (Level 3).

8.2   We identified a total of 100 separate actions. We asked the Trust to provide evidence that actions had been implemented. By this we mean that we need to see the policy that had been written, the training that had been provided, and the audit that had been carried out.

8.3   The Trust was able to provide this evidence for four-fifths of actions – one third were implemented to Level 3, with just under one-fifth implemented to Levels 1 and one-fifth to Level 2. For a few actions, we did not request evidence as the actions referred to specific individuals. A small number of actions from the most recent reports were still in progress.

8.4   The actions were in the main SMART (Specific, Measurable, Achievable, Realistic and Time bound). The more recent action plans identified the person or role responsible for ensuring that actions were implemented; identified a clear timescale; and listed the type of evidence that would demonstrate implementation.

8.5   In most cases, the action plans reflected the recommendations accurately, although there were discrepancies in a small minority of cases.

8.6   We noted that there were a large number of actions, and that some were repeated over time and different services.   This suggests that, over this period of time, changes in practice had not been fully implemented across all services within the Trust.

8.7   We requested, over a period of time, the Trust to provide the evidence required to fulfil this item of the Terms of Reference. There was perhaps some difference of interpretation of what we meant by 'evidence'. In the first instance, the Trust provided evidence in the form of statements/assertions that work had been done and change made. We needed to see evidence documented – for example, the policy that had been written or the audit that had been carried out. We do recognise that interrogating historical systems may not be easy.

8.8   The Trust informs us that a new system has been introduced so that documentary evidence that actions have been completed is electronically embedded into the action plan itself, or there is a direct link to the evidence. This should ensure that in the future the Trust can monitor implementation of action plans more easily, and provide evidence to external bodies more readily where this is appropriate.

8.9   One recurrent theme in some of the action plans was the need to involve families and carers more effectively. We note that the Trust has made a commitment to the Triangle of Care[6]. We support the Trust in this commitment and have detailed the steps that the Trust needs to take in order to achieve its aim of membership of the national scheme.

8.10   Finally, we recommend that the Trust should expect recommendations and action plans from internal homicide inquiries to focus on outcomes (changing

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[6] A nationally recognised systematic approach to engaging and supporting carers and families of mental health service users.

practice) and impact (on stakeholders such as staff, service users and their carers) rather than process (developing a policy, providing training).

9   Board assurance and governance

9.1   We reviewed the systems and processes which would enable the Board of Directors to assure themselves that lessons were being learnt from homicides (and other serious incidents). We looked for systems that would show if recommendations and actions were being embedded within the organisation, and the lines of accountability within the Trust[7].

9.2   First, we reviewed the systems and processes that the Trust has in place now – we have not considered the changes which the Trust has developed and refined over time. The policies and guidance covered:
- guidance on trends and learning lessons
- risk management
- reporting and managing serious incidents
- 'Being Open' and the Duty of Candour[8].

9.3   The Trust provided five policies and guidance for us to review. One had not been reviewed within the agreed timescale; one was an incomplete draft; and one had not been approved by the relevant committee.

9.4   These policies included information on how the Trust monitors whether services are implementing these policies in practice, and the evidence that the Board required.

9.5   Notwithstanding the fact that not all were up to date and ratified, we consider that the substance of these policies to be robust and appropriate. The Trust has established clear lines of accountability and responsibility for reporting, investigating and learning from homicides and other serious incidents. There are clear systems for monitoring all aspects of the entire process.

9.6   Second, we considered examples of how these systems and processes were working in practice, primarily through a review of published Board papers. Again, we considered only those items which relate to homicides and other serious incidents.

9.7   In practice, we identified a number of areas where the Trust should build on the improvements already taking place. These include:
- improving the effectiveness of links between corporate governance and local governance processes[9]
- variable reporting of incidents in different Care Delivery Services (CDSs)

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[7] The sources of information we reviewed for this section of the report are listed in detail in Appendix C, Methodology in Volume 2.

[8] The Duty of Candour is a legal requirement that all Trusts must keep service users and their families informed, apologise to them and offer the opportunity for them to contribute to any investigation and to be informed of the outcome of that investigation, when health care goes wrong.

[9] This was identified by a CQC inspection in February 2015. In January 2016 the Trust rated its progress towards achieving this as 'Amber' and continues to monitor progress.

- completion of serious incident reviews within the required timescale in just under half of cases.

9.8 The Trust was taking steps to achieve improvements, such as:
- Clinical Directors take an active role in the monitoring and reporting structure.
- The Trust is developing 'policies on a page' to make it easier for frontline staff to read and understand what actions policies require.
- The Trust sends a 'Report and Learn Bulletin' to all staff which contains changes recommended after any serious incident happens. This is used as the basis of discussion and reflection at staff meetings so that lessons can be learnt across the Trust and changes made to practice where appropriate.
- Good governance arrangements were in place for the CDS's to share learning from serious incidents.

9.9 Trust Board papers identified areas for improvement in care and service delivery from a range of sources (e.g. inquests, complaints) covering the months of October to December 2015. These issues were the same as some of those identified in the thematic review of homicide reports.

9.10 Trust processes are therefore effective in identifying these areas of practice and bringing them to the attention of the Board of Directors. The outcomes of these processes suggest that there continues to be work for the Trust to improve care and service delivery, and patient safety.

9.11 We commend the actions the Trust is taking and conclude that there remain risks in these areas. We recommend that the Trust builds on the improvements already underway and continues to work on:
- improving the connection between corporate and local governance procedures
- evidence-based mechanisms for ensuring that lessons from all incidents are learnt
- embedding and evidencing changes to practice across the organisation as part of a continuous improvement cycle.

10 Recommendations

10.1 Throughout this review, we have noted a tendency in mental health homicide investigation recommendations and Trust action plans to focus on processes and activities (for example, re-writing policies, providing training).

10.2 In order to improve the quality of care and treatment provided by this and other mental health mental health trusts, and to reduce the likelihood of similar incidents recurring, we consider that the focus should move towards outcomes, changes in clinical practice (for example, on the completion of risk assessments across the Trust for all clients) and the impact of practice on stakeholders, including service users, carers, families, health care professionals and support staff, and the broader public.

10.3 The recommendations below are designed to support NHS organisations to provide this focus and to facilitate more outcome and impact based practice in the investigation (internal or independent) process.

10.4 The recommendations below are listed in order of priority for each organisation.

Recommendations for the Trust

10.5   The Trust and its Board of Directors are asked to consider implementing the following:

   i.   The Board of Directors should monitor the implementation of the CDS structure and the use of the Safeguard Serious Incident recording system (Ulysses) to assure itself that investigation management and implementation of action plans are consistent with Trust policies, processes and systems.

   ii. The Board of Directors should build upon the work already in place to assure themselves, their stakeholders and the wider public that learning from all recommendations is being fully embedded across the organisation in a timely manner. Currently and in the future, where there is Level 1 evidence, the Board should be expecting the Trust to move towards Level 2 compliance with recommendations; and likewise, where there is Level 2 evidence the expectation of Level 3 evidence should be made clear. If these are not appropriate, then the Trust should be clear and transparent as to the reasons.

   iii. The Board of Directors should assure themselves that there are robust systems in place to provide evidence that actions have been implemented in a timely manner and in line with the requirements of each action plan.

   iv. The Trust should ensure that clinical staff have dedicated time for recording notes and record keeping; that staff record the rationale for the clinical decisions they make; and use risk assessment and formulation to inform relapse planning.

   v.   The Trust should investigate the feasibility of technological solutions to make it easier to complete records and improve productivity. This might include the use of voice recognition technology when recording on the electronic record system.

   vi. The Trust should develop a checklist of key requirements, based on the themes identified in this report, to be used at all CPA reviews.

   vii. When the Trust evaluates training and education, they should evaluate not only the learner experience but also the impact of the training, using a model such as Kirkpatrick[10]:

       a. Level 1: Reaction (Staff enjoyed and engaged in the training)
       b. Level 2: Learning (Staff acquired the intended knowledge, skills and commitment from the training)

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[10] Kirkpatrick L *The Kirkpatrick Model* http//:www.kirkpatrickpartners.com (access 9 June 2016)

c. Level 3: Behaviour (Staff apply what they learned back in the workplace)

d. Level 4: Results (Achievement of organisational targets or goals as a result of the training).

viii. The Trust should continue to act on its commitment to implementing the 'Triangle of Care' approach to involving carers in the care and treatment of service users. The Trust should aim to achieve membership of the national programme within 12 months.

Recommendations for the Clinical Commissioning Group

10.6   The CCG is asked to consider implementing the following recommendations:

i. The CCG should commission services which explicitly ensure that clinical staff complete fundamental tasks, such as recording, implementing the CPA, including risk assessment and management.

ii. The CCG should specify that providers carry out audits of quality rather simply using electronic systems to count the number of times things are done.

iii. The CCG should specify that providers carry out patient safety auditing of basic practice – e.g. recording, assessments, risk management planning.

Recommendations for NHS England

10.7   NHS England is asked to consider implementing the following recommendations:

i. NHS England should require independent investigation teams to produce not more than three high-impact key recommendations; if, in exceptional circumstances, the team considers that more are absolutely necessary, these should be listed in order of priority for improving the service/reducing the likelihood of recurrence.

ii. NHS England should either:

a. require independent investigators to use nationally standardised criteria when deciding whether a homicide was predictable or preventable; or:

b. remove the requirement to consider predictability and preventability from the core terms of reference, on the grounds that this incompatible with the 'learning lessons' ethos of the Serious Incident Framework (2015) and the principles of Root Cause Analysis.

iii. NHS England should require investigation teams to focus recommendations on outcomes rather than processes when the Serious Incident Framework is next revised.

iv. NHS England should require investigation teams to focus recommendations on supporting staff to change behaviour and practice (for example, through supervision, performance management, coaching techniques, using a

solutions-focussed approach to managing people and developing the organisation).

v.   NHS England should commission independent investigation teams to evaluate the impact of organisational learning when they review implementation at six months, at the same time as focussing whether or not actions have been completed.

vi.   As commissioner of specialist services NHS England should hold discussions regarding access to specialist services such as neurobehavioral services.