An independent quality assurance review following the independent investigation into the care and treatment of a mental health service user Mr S in Teesside

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

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1. INTRODUCTION

The incident

1.1 Tees, Esk and Wear Valleys NHS Foundation Trust (referred to as TEWV hereafter) and Berkshire Healthcare NHS Foundation Trust (referred to as BHFT hereafter) were the main focus of the independent investigation.

1.2 Mr S was alleged to have killed the victim on 24 December 2015. He had been introduced to the victim through his stepfather who lived in the south of England. Prior to this, he had been residing in the TEWV catchment area. At the time of the homicide, Mr S was living in the Thames valley area, staying at the victim's house.

1.3 Mr S was under the care of the TEWV Early Intervention in Psychosis Team (EIPT) at the time of the offence but had disengaged from services and moved to the south of England without the knowledge of the team in late November 2015. He was referred by TEWV to BHFT in 11 December 2015 when they became aware, he had moved after a conversation with a relative.

1.4 Whilst the TEWV referral was being processed, a GP referral to the BHFT Crisis Resolution Home Treatment team (CRHTT) on 23 December 2015 and subsequent telephone discussions with Mr S and his stepfather on 24 December 2015 resulted in a plan for the CRHTT to visit him for assessment and medication purposes (i.e. giving him a depot injection). Two visits to Mr S on the 24 December were unsuccessful, as he was not residing at the address given. A third visit was planned for later in the evening of 24 December 2015 to the correct address where Mr S was staying with the victim.

The independent investigation

1.5 NHS England North commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr S. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.6 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the

[1] *NHS England Serious Incident Framework March 2015.* https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidents* https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

investigation of serious incidents in mental health services.

1.7 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.8 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.9 The independent investigation was carried out by Sue Denby, Lead Investigator for Niche, with expert advice provided by Dr John McKenna, Consultant Forensic Psychiatrist.

1.10 The independent investigation report was published in November 2017. The independent investigation made 6 recommendations for the agencies involved to address in order to further improve learning from this tragic incident.

Findings and recommendations arising from the independent investigation

1.11 It was our view that the homicide was not predictable. Risk assessments were regularly undertaken and Mr S was not thought by TEWV to be a risk to others apart from his mother, although he had voiced concerns that he would hurt others. It is our view that his mother was advised appropriately about safety measures including involvement of the police and consideration of safe houses.

1.12 However, it was our view that had certain interventions taken place the outcome may have been different. TEWV and BHFT both had knowledge that the depot medication was overdue and both organisations could have initiated joint planning to ensure this was administered in a timely way as soon as possible following referral. Joint planning could potentially not only have ensured depot administration, but also that other interventions (e.g. housing) and monitoring (of mental state) were in place, hence potentially averting the eventual sequence of events.

1.13 Given that medication was prescribed at a lower dose, and that this was in effect sub-therapeutic after 13 weeks, Mr S was clearly at increased and significant risk of relapse. Mr S himself, the GP, and other family members all requested on 23 and 24 December 2015 that the depot should be administered due to their concerns about the deterioration of his mental health.

1.14 The BHFT internal investigation indicates that on 24 December 2015 at 1.20pm the victim telephoned the Community Health Hub asking for help for

Mr S. Mr S came on the line and said "*I need my antipsychotics; I was supposed to get them yesterday*".

1.15 Community health staff informed CPE of this call and at 1.42pm a CPE nurse telephoned the victim who explained that Mr S was staying with him and had been aggressive and was "*not compos mentis ... he's all over the place ... he's getting worse ... he is self-harming*." The nurse asked to speak to Mr S and the victim indicated that Mr S was sitting on the sofa "*totally silent"* and unable to speak to the nurse. This picture of Mr S echoes his past presentation when overtly acutely psychotic.

1.16 However, it was not clear whether the administration of the depot injection at an early stage following referral would have been a sufficient measure alone to have prevented the homicide from occurring as it is likely that risk to others included a combination of issues associated with his medication compliance, chaotic living arrangements and drug use.

1.17 It was our view that the care coordinator made continuous efforts to support Mr S to live a stable, independent life however the fact that Mr S moved to the Thames Valley area and was staying with the victim was not within the control of the care coordinator and the extent of his drug use at this time was unknown.

1.18 The key issues highlighted in the independent investigation relate to relatively basic operational and good practice issues, especially relating to information sharing and communication.

Recommendations

1.19 The independent investigation made six recommendations for TEWV (henceforth 'the Trust') to address in order to further improve learning from this tragic event.

Recommendation 1:
TEWV must develop an agreed set of local policies and procedures to be regularly reviewed by key strategic partners in line with the November 2016 NICE[3] guidance on coexisting severe mental illness and substance misuse: community health and social care services.

Recommendation 2:
TEWV must review the EIPT operational policy to set out agreed methods and expectations around multidisciplinary working, to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns, and at least annually, where patients are receiving antipsychotic medication.

Recommendation 3:
TEWV must review the TEWV EIPT job plans to ensure consistent medical input to the team.

Recommendation 4:
TEWV must develop a schedule of audit for crisis plans and take action as required so that they meet the CPA policy standard.

Recommendation 5:
TEWV must review the TEWV CPA policy to ensure that overdue depot medication is communicated effectively in referral procedures and correspondence, e.g. by 'phone.

Recommendation 6:
TEWV must take action Trust-wide to ensure that any referral made to an external or internal service indicates clearly the level of urgency.

Structure of the report

1.20 Section 2 describes the process of the review, and Section 3 reviews in detail the actions planned in response to the independent investigation, and the progress the organisation has made in implementing the recommendations and embedding change.

1.21 Section 4 sets out our overall analysis and conclusions.

[3] *NICE stands for the national institute for health and social care excellence and it provides evidence-based guidance, advice and information services for health, public health and social care professionals.*

Summary of findings of this assurance review

1.22 The external quality assurance review comprised of meetings and interviews with senior managerial staff from the above organisations and a review of documents and policies provided by responsible people in the organisations, as evidence of completion.

1.23 The external quality assurance review commenced in December 2018 and was completed in May 2019, and was carried out by:

- Nick Moor, Partner, Investigations and Reviews, Niche Health and Social Care Consulting

1.24 We have graded our findings using the following criteria:

Grade	Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

1.25 The overall conclusion of the review is that all six recommendations actions are complete.

1.26 We are unable to give a full assessment of completion, embeddedness and impact (i.e. Grade A) for any recommendations.

1.27 We recognise that some of the actions will take much more time to become embedded practice.

1.28 The overarching concern of the independent investigation report was focussed on monitoring medication for people in contact with EIP, that EIP services received consistent medical input to help monitor anti-psychotic medication and that the urgency of need was communicated clearly in referrals (both internally and externally).

1.29 In order to fully demonstrate that the services have changed practice and the Trust is now assured of implementation, the Trust should provide further robust evidence of the changes to practice as discussed in this report.

1.30 We note the efforts of all concerned with this action plan, and especially the development of the new Clinical Link Pathway for Dual Diagnosis.

Grading of implementation of actions

Recommendation 1	Niche Grade
TEWV must develop an agreed set of local policies and procedures to be regularly reviewed by key strategic partners in line with the November 2016 NICE guidance on coexisting severe mental illness and substance misuse: community health and social care services.	**C**
Recommendation 2	**Niche Grade**
TEWV must review the EIPT operational policy to set out agreed methods and expectations around multidisciplinary working, to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns, and at least annually, where patients are receiving antipsychotic medication.	**C**
Recommendation 3	**Niche Grade**
TEWV must review the TEWV EIPT job plans to ensure consistent medical input to the team.	**C**
Recommendation 4	**Niche Grade**
TEWV must develop a schedule of audit for crisis plans and take action as required so that they meet the CPA policy standard.	**C**
Recommendation 5	**Grade**
TEWV must review the TEWV CPA policy to ensure that overdue depot medication is communicated effectively in referral procedures and correspondence, e.g. by ‘phone.	**C**
Recommendation 6	**Niche Grade**
TEWV must take action Trust-wide to ensure that any referral made to an external or internal service indicates clearly the level of urgency.	**C**

2. ACTION PLAN PROGRESS

2.1 The independent investigation was published in November 2017.

2.2 It was agreed that an assurance review of the implementation of the action plan would be carried out within six months of publication. The relevant section of the terms of reference is:

"Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CCG and Trust and feedback the outcome of the assessment to NHS England North."

2.3 We have been provided with an action plan, date agreed as 28 July 2017. This action plan states that all actions are either completed or 'action on track for completion date'.

2.4 It is acknowledged that this homicide has had far reaching effects on mental health services in Teesside. There have been programmes of work that have been focussed on addressing many of the underlying problems around standardisation of practice, record keeping and management of young people with psychosis. The intention was that the learning from this tragic event should become embedded in everyday practice.

2.5 In the following section we review the implementation of actions by TEWV.

Recommendation progress

Recommendation 1	Niche Grade
TEWV must develop an agreed set of local policies and procedures to be regularly reviewed by key strategic partners in line with the November 2016 NICE[4] guidance on coexisting severe mental illness and substance misuse: community health and social care services.	**C**

2.6 The expected outcome was:

- A new set of local policies and procedures, regularly reviewed and agreed by partners in line with the November 2016 NICE guidance on coexisting severe mental illness and substance misuse: community health and social care services

2.7 The expected evidence of this implementation was:

- Copy of any new policies developed.

[4] *The guidance referred to is "**Coexisting severe mental illness and substance misuse: community health and social care services "NICE guideline [NG58] Published date: November 2016***

- Evidence of review with key strategic partners, including identification of these partners.

- Evidence for dissemination of the revised policy.

- Copies of communications/emails/notes of meetings or training days and attendance (who and as percentage of total staff) where it was discussed.

- Evidence of assessment of impact such as audit, and evidence of assurance that the policy is embedded and operational (i.e. any audits and case sampling done to provide assurance). Examples of any reports sent to Board quality sub-committee or other quality monitoring and oversight meetings.

2.8 We were told that a baseline assessment has been completed against the NICE guidance with an associated plan of work to enhance practice, and a Trust-wide Dual Diagnosis lead appointed.

2.9 Also, that a “Rapid Process Improvement Workshop” on dual diagnosis had taken place in Stockton locality as part of a series of four workshops across Teesside in 2017/ 18. This focussed upon the clinical pathway for patients across different provider organisations, and was attended by “drug/alcohol provider, service users/carers/TEWV/social care/CCG/public health/ and GP”. We have seen the presentation slides used for this event, although these did not identify the dates of the event.

2.10 The current Policy review date has also been extended and that the Policy review will incorporate findings and actions associated with “NG58 assessment and action plan” above, and the Trust will develop a Dual Diagnosis Training Clinical Link Pathway (CLiP).

2.11 These actions have all been recorded as complete.

2.12 We have not seen a copy of the baseline assessment against the NICE guidance. However, we have seen the revised “Care and Management of Dual Diagnosis Policy”, Policy Number: CLIN/0051/v5, Issue/Version No.: 5. This is an eight-page document. We note that this was reviewed in March 2017. However, we are unable to see any differences between this revised policy and the policy in existence at the time of the homicide and provided to the independent investigation.

2.13 We have also seen the “NICE Guidance Implementation for NG58: Coexisting severe mental illness and substance misuse – community health and social care services” dated 18 May 2017, from the Clinical Effectiveness Group. This identified four actions as ongoing:

- Review of best practice guidance by senior clinical staff.

- Identification of attitudes and confidence levels of adult mental

health staff in working with services with substance misuse and mental health problems through focus groups with staff.
- To understand the experience of service users and carers and to use this in development work.

- Provide clear guidance on best practice for this group.

2.14 These were all marked as 'ongoing' at 18 May 2017.

2.15 We have noted the "Mental Disorder and coexisting Substance Misuse (Dual Diagnosis) Clinical Link Pathway (CLiP)" approved 15 March 2018. The purpose of this document is "*to develop a clinical pathway for dual diagnosis that is compliant with national guidance by NICE and the UK guidelines on clinical management of drug misuse and dependence (Orange Book). It aims to replace the clinical aspects of the Trust's policy and procedure for Care and Management of Dual Diagnosis*."

2.16 This is a comprehensive 37-page document which is well referenced and provides a solid evidence base for practice. The CLiP covers:

- Standards of good practice.
- Routes of access to care.
- Service models.
- Care coordination.
- Stigma and attitudes.
- Discharge.
- Multiple needs.
- Safeguarding.
- Family/carer involvement.
- Joint working.
- Substance misuse specific interventions in mental health services.
- Assertive practice.
- Initial contact and screening.
- Alcohol.
- Drugs.
- Detoxification and management of withdrawal.
- Special groups (elderly, young people).

- Interventions (psychosocial interventions and care planning, pharmacological interventions).
- Dependence (alcohol, benzodiazepine, stimulant, cannabis, nicotine, opioid).
- Pain and dual diagnosis.

2.17 We have been provided with a copy of the draft "Protocol for management of substance misuse in in-patient settings" dated 13 November 2018. Again, this is a comprehensive and well referenced document providing guidance to in- patient staff on the management of services users with co-existing mental health and substance misuse problems in in-patient settings. We note the group involved in the development of this protocol includes:

- Consultant Psychiatrist, Trust Lead for Dual diagnosis, Clinical Director Adult Mental Health, Durham and Darlington.
- Associate Nurse Consultant in Dual Diagnosis.
- Head of Nursing, Teesside.
- Ward Manager, Stockdale Unit, Roseberry Park Hospital, Middlesbrough.
- Service Development Manager, Adult Mental Health.
- Consultant Psychiatrist, Clinical Director Adult Mental Health, North Yorkshire.
- Trust Lead for Acute Care Services.
- Consultant Psychiatrist.
- Chief Pharmacist.

2.18 This protocol references the above CLiP. The protocol covers:

- How to optimise management of drug and alcohol use on the ward
- CLiP Dual Diagnosis.
- Prescribing and management on the ward (methadone, buprenorphine, naloxone).
- Prevention and management of overdose after discharge.
- Management of overdose.
- Alcohol
- Detection of drug or alcohol use on the ward, drug testing,

searching of patients, property, environment and visitors and drug dog.

- What to do if patients use drugs or alcohol on the ward and the patient ‘compact’.
- Involving dual diagnosis workers, peers and specialist staff.
- Formulation stop the line or MDT meeting.
- Standards for discharge of dual diagnosis patients.

2.19 We have also been provided with further documents as evidence of implementation of this recommendation. The first is guidance on Harm Minimisation, which stresses the need to promote recovery and work in co- production with service users. This is undated and has no clear status.

2.20 The second document is “Guidance for staff employed by TEWV in the use of mobile phones to communicate with service users”. This is dated July 2016. This guidance stresses the value and purpose of mobile phones as a communication tool with clinical staff, and their use in engaging service users. However, the guidance also stresses the need for clear guidelines for responding to message es, and co-production of care plans which identify the use of mobile phone as method of communication, hours of use and how staff will respond when messages are not responded to. Both of these procedures seem to be practical and aimed at safe practice and increasing engagement.

2.21 Lastly, we have been provided with a slide deck for a ‘sharing success event’ which outlined the Trust strategic approach for improving dual diagnosis services. Although the programme sensibly appears to outline a practical and improvement focussed approach to addressing the increasing complexity and number of presentations of dual diagnosis and the roll out of the CLiP and the protocol for in-patient settings, this presentation is undated, the status is unclear, and we have no identification of the number of people who have received this information.

2.22 Because the CLiP is such a comprehensive document, we can grade this as ‘C’ (evidence of completion).

2.23 We are aware that the CLiP is intended to replace the policy, and we have seen communications from Trust senior management that from ‘Q2 18/19’ (i.e. June – August 2018) that the CLiP will be used in all services. We have not been provided with any evidence of audit of implementation of the policy.

2.24 Therefore, the Trust should now work to provide assurance that the new ways of working in the CLiP and the draft in-patient protocol are now being embedded in routine practice.

Recommendation 2	Niche Grade
TEWV must review the EIPT operational policy to set out agreed methods and expectations around multidisciplinary working, to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns, and at least annually, where patients are receiving antipsychotic medication.	**C**

2.25 The expected outcome was:

- A new local policy with methods and expectations around multidisciplinary working and procedures, which ensures that when patients are receiving antipsychotic medication, senior medical staff are involved appropriately in discussions about patients, at least annually, and where staff have concerns.

2.26 The expected evidence of this implementation was:

- Copy of revised policy.
- Minutes of discussion reviewing the policy.
- Evidence that senior medical staff are involved appropriately (audit/ monitoring) of subset.
- Evidence of oversight and feedback to the appropriate level senior team responsible for monitoring performance.

2.27 In our independent investigation we were told that the advanced practitioner would undertake a medication review following a team request and discussion that this would generate options. The advanced practitioner may also be asked to undertake a medication review without this discussion taking place, that they would normally be able to anticipate the situation in hand and discuss the plan with the consultant in the team beforehand.

2.28 However, neither the advanced practitioner nor the consultant could recall a discussion having taken place, although the decision was recorded in the electronic care record and in a letter to the GP. We were concerned about this given that Mr S had not seen a psychiatrist for seven months or a consultant for twelve months and viewed this lack of a discussion as a lost opportunity to review the risk issues associated with the change.

2.29 Accordingly, we recommended that the EIPT operational policy sets out agreed methods and expectations around multidisciplinary working, so as to ensure that senior medical staff are involved appropriately in discussions about patients where staff have concerns, and review patients at least annually where they are receiving antipsychotic medication.

2.30 The action plan for this recommendation states that “Daily huddles are in place within the EIP team. The need for medical input is identified via this clinical meeting. The EIP operational policy is encompassed in the Model Line pathway. There is a planned Trust-wide review of the Model Line pathway in November which will reinforce the requirements in relation to medical input for patients in receipt of anti-psychotic medication”.

2.31 The actions have all been recorded as complete.

2.32 We have seen evidence that ‘daily huddles’ have a set agenda and have a template for recording each huddle. We understand they happen on a daily basis.

2.33 We have been provided with a copy of the Model Line pathway in a presentation shared with staff.

2.34 We have been provided with a copy of the Early Intervention in Psychosis Service Operational policy, dated March 2014. This predates the incident and our independent investigation, and there is no evidence that it has been reviewed in the light of our recommendation. There is no evidence that this policy has been formally ratified, unlike the “Care and Management of Dual Diagnosis Policy”.

2.35 This policy states that the “service aims to follow a standard, locally developed ‘Psychosis Care Pathway’ which has been developed to reflect best practice” and that there will “be robust arrangements to provide medical input in each geographical area, contributing to assessment and ongoing treatment either within the service, or by arrangements with adult mental health or CAMHS psychiatrists working in community teams”.

2.36 We have been provided with evidence of the intended medical input in the form of a ‘Medic Appointment’ process guidance/ checklist for the Psychosis Model Line. This guidance explains that the “purpose of this appointment with the Psychiatrist is to engage the service user, to make sense of their difficulties, consider a diagnosis, to formulate a treatment plan including medication options. To support a true multidisciplinary and holistic approach by providing their medical expertise and contribute to the 6-week formulation”. We have also been provided with a template letter to be sent from the psychiatrist to the GP following the first medical appointment. This discusses medication.

2.37 We have also seen some ‘notes/actions’ of the EIP Steering Group, dated 18 June 2018. These notes identified no actions being progressed with completion listed as either ‘on-going’, or for ‘July or August 2018’. However, none of the actions were concerned with implementing this recommendation.

2.38 We have not seen any evidence that the Trust is monitoring those EIP cases receiving antipsychotic medication to ensure that senior medical staff are involved appropriately in discussions about them, at least annually, and where staff have concerns.

2.39 The recommendation required the Trust to provide a "new local policy with methods and expectations around multidisciplinary working and procedures, which ensures that when patients are receiving antipsychotic medication, senior medical staff are involved appropriately in discussions about patients". Because we have seen the Medic Appointment, and template letter the evidence for assurance of implementation of this action is complete, and graded this at 'C'.

2.40 In order to grade this as embedded the Trust now need to provide robust assurance that EIP services users receiving anti-psychotic medication have medical staff involved in discussions about their care at least annually and where there are staff concerns.

Recommendation 3	Niche Grade
TEWV must review the TEWV EIPT job plans to ensure consistent medical input to the team.	C

2.41 The expected outcome was:

- A review of EIPT job plans to ensure consistent medical input to the EIPT.

2.42 The expected evidence of this implementation was:

- Evidence of review of EIPT job planning.
- Demonstration of adequate consistent medical input.
- Evidence of discussion about what is adequate and consideration of need.

2.43 The action plan states that "the EIPT has dedicated medical input via a nominated Consultant and an Associate Specialist which has been job planned. Additional funds have been made available via CCG's to recruit additional medical capacity (0.5 wte) to Tees EIP service". These actions are "completed" (job plan) and "action on track for completion date" (additional fund/recruitment).

2.44 We have seen evidence of dedicated medical input and job plan to the EIPT, with the appointment of additional medical capacity.

2.45 We have been told that there is an understanding that all psychosis consultants support EIP clinical work within their relevant clinical areas, and has been part of their job plans for several years. Alongside this there is some dedicated time from a Specialist Registrar (SpR) (1 session/week, and for the last several months it is utilised as 1 day every 2 weeks) for EIP. A new specialty doctor post has been created which also covers EIP (along with Middlesbrough psychosis), and interviews were held recently, and the

Trust is in the process of getting more consultant medic time for EIP on a part time basis, as it is believed they have not been commissioned to provide a full time medic consultant in Teesside EIP.

2.46 Because there is a job plan and dedicated medical input to the EIPT we have graded this action as complete, 'C'. The Trust now need to provide robust assurance that they have reviewed the medical input to EIP and provide job plans to ensure consistent medical input into EIP.

Recommendation 4	Niche Grade
TEWV must develop a schedule of audit for crisis plans and take action as required so that they meet the CPA policy standard.	**C**

2.47 The expected outcome was:

- A schedule of audit for crisis plans and evidence of actions taken to ensure that crisis plans meet the Trust CPA policy standard.

2.48 The expected evidence of this implementation was:

- Audits of crisis plans.
- Evidence of actions taken when required.
- Assurance that crisis plans now meet CPA policy standard.

2.49 The internal action plan states that "Team to undertake audit on planned cycle basis of CPA. Stockton EIP are a Pilot site in Trust-wide Recovery Project. Experts by Experience are involved in auditing the co-production / quality of care and crisis plans through contact with current patients and families – audit recommendations will be acted upon". The planned cycle of audit for CPA was recorded as 'on track for completion date' and the EIP pilot audit was recorded as 'completed by the recovery team'.

2.50 In our independent investigation we found that care plans described interventions regarding physical health, accommodation, mental health, potential risk to children, risks of non-attendance, lack of insight, self-neglect, cannabis use, vulnerability, carers' views, alcohol and drug use, vocation and activity, finance and medication. In June 2015 family work was suggested by the care coordinator to help support Mr S and his mother in their communication with each other which they agreed to think about.

2.51 Each action in the care plan had a contingency and the care plan itself had a crisis action section. However, for all of these, the action was to contact the care coordinator, the team or the duty system with telephone numbers

provided. This did not adhere to the TEWV CPA policy on crisis plans where it asked that crisis plans have warning signs, relapse indicators and actions. It was not known whether this was just an EIPT or a TEWV wide issue. It was therefore our view that crisis plans should be audited, and action taken as required to meet the CPA policy standard.

2.52 We have been provided with examples of two audits. These were:

i. Clinical Audit of Harm Minimisation – Community Services, May 2017.
ii. Clinical Audit of Crisis Planning within the York and Selby Early Intervention in Psychosis (EIP) Team, September / October 2018.

2.53 The 'Clinical Audit of Harm Minimisation' sampled 285 records from community caseloads across the Trust from over 70 teams. The audit used the following criteria, drawn from the Trust Harm Minimisation policy. The expected standard for compliance with policy was 100%.

Criteria
All service users will have the clinical risks presented by them assessed, formulated and reviewed as often as deemed necessary.
The risk assessment will consider the following for each service user: harm to self, harm to others, harm from others and other harms and risks.
The risk assessment will consider the level of concern for each of the following: harm to self, harm to others, harm from others and other harms and risks.
The service user, families/carers and any other professional groups will be included in the formulation and management of clinical risks whenever appropriate and possible.
All service users will have evidence of a recovery oriented final plan.

2.54 This audit showed that overall an 'amber compliance' rating was applied to the report. It showed that "standards of practice were in place and showed good levels of implementation across the Trust. However, there remain areas for practice improvement which are currently being addressed by the ongoing Harm Minimisation Project (and training), PPCS, Recovery and Care Planning work streams. The Harm Minimisation training is providing a particular mechanism for addressing issues highlighted by the audit with staff directly. Training materials have been informed by and adapted as a result of audit findings. Implementation of the identified action plan will further support practice improvements in addition to the existing Trust work streams."

2.55 Key issues identified included:

- The final plan on the safety summary did not involve the service user's family, where appropriate, in 60% (97/161) of cases.

- There was no alternative support pathway for service users who are difficult to engage with (a clear safety/crisis plan) in 78% (112/144) of cases.

- The safety summary/crisis plan did not look at reducing access to means in 71% (107/151) of cases.

2.56 The 'Clinical Audit of Crisis Planning within the York and Selby Early Intervention in Psychosis (EIP) Team" audited 32 service user records. The audit criteria were taken from Tees, Esk and Wear Valley, (2016) *'Care Programme Approach and Standard Care'* and the '*Model Lines, Staying Well Plan'* (2015). The expected standard for compliance with policy was 100%.

Criteria
All patients who have been allocated to the Care Programme Approach must have a crisis contingency plan documented within their overall care plan
Documentation within Paris should reflect the "staying well work" completed within the model lines pathway and evidence that this has been completed collaboratively.
The crisis contingency plan must include all relevant contact details including an out-of-hours contact number for services
The crisis contingency plan should be individual to the person and detail: • Particular ways of behaving when distressed. • Early warning signs and relapse indicators. • What helps or doesn't help in an emergency or crisis.
A service user's own caring responsibilities should also be explored and appropriate support, contingency and crisis plans put in place for the service user as a carer and for the person they care for.
Copies of the plans should be offered to the service user and given to his or her GP and any other significant care provider, including carers, if appropriate.

2.57 This audit showed that of the 19 applicable crisis plans included within the audit, 84% (16/19) provided all relevant contact details including an out-of- hours contact number for services.

2.58 Overall, the quality of some aspects of the crisis plans was detailed and comprehensive. Examples of this included:

- A thorough description of early warning signs and the progression of these throughout the illness to crisis point.

- Each sign has corresponding strategies to put in place to help manage these more effectively and safely.

- Detailed step by step instructions of grounding techniques using the five senses, mindfulness, distraction techniques and contact details.

- Two of the crises plans that were audited documented factors that 'do not help' during a crisis situation.

2.59 Alongside this, 68% (19/28) of patients had a crisis contingency plan documented within their care plan, 79% (15/19) of crisis plans supported the completion of help to identify triggers and early warning signs. Evidence for all 15 could be located within the patients Care Plan under the 'Crisis/Relapse Actions' section.

2.60 The audit found that 63% (12/19) of crisis plans provided evidence to support that the patient had worked together with staff members.

2.61 Crisis Planning forms an integral part of the patients care plan due to its over- arching aim of minimising the level of risk to prevent and manage a crisis situation and therefore thus prevent any unnecessary harm to the patient and/or others. The audit found the care plans identified the following:

- Particular ways of behaving when distressed - 79% (15/19)
- Early warning signs – 79% (15/19)
- Relapse indicators – 74% (14/19)
- What helps or doesn't help in an emergency or crisis – 74% (14/19)

2.62 The audit concluded that "an amber compliance rating was assigned to this clinical audit report. There was no evidence of nine patients having a crisis contingency plan documented within their care plan. The results showed inconsistent recording of key aspects of the contingency plans in place and relevant evidence of sharing the plan with appropriate individuals."

2.63 The evidence for assurance of implementation of this action shows that the Trust have completed at least two audits concerning safety and crisis planning for community servicer users. We have graded completion of this recommendation at 'C', complete.

2.64 In order to improve this grading, the Trust should provide evidence of actions taken as a result of the findings, and then re-audit to demonstrate improvement.

Recommendation 5	Niche Grade
TEWV must review the TEWV CPA policy to ensure that overdue depot medication is communicated effectively in referral procedures and correspondence, e.g. by 'phone.	C
Recommendation 6	
TEWV must take action Trust-wide to ensure that any referral made to an external or internal service indicates clearly the level of urgency.	C

2.65 We agreed with the Trust to review the assurance for completion of these two actions together, since they were closely linked in intention and completion.

2.66 For Recommendation 5 the expected outcome was:

- Evidence that the Trust had reviewed the CPA policy to ensure that overdue depot medication is communicated effectively in referral procedures.

2.67 The expected evidence of this implementation was:

- Revised CPA policy that ensures that overdue depot medication is communicated effectively in referrals and correspondence.
- Evidence of audit to provide assurance that policy is being implemented.

2.68 For recommendation 6 the expected outcome was:

- Assurance from the Trust that any referral made to an external or internal service indicates the level of urgency.

2.69 The expected evidence of this implementation was:

- Example of revised policy to ensure new referrals made clearly identify level of urgency.
- Meeting discussions where this policy was developed.

2.70 In our independent investigation we found that the potential risks associated with the depot medication being overdue were not communicated effectively in the referral correspondence from TEWV to BHFT. The response from BHFT was therefore not seen as urgent, and Mr S had received a suboptimal dose of anti-psychotic medication over a thirteen-week period, which increases the risk of relapse.

2.71 The internal action plan notes that "CPA policy to reflect procedure for information to be shared in transfer of CPA to another service. Audit of Transfers to ensure adherence to Policy". The actions were recorded as completed (CPA Policy) and on track for completion (audit of adherence to policy).

2.72 We have been provided with a copy of the policy document 'The Care Programme Approach and Standard Care', Ref 1A -0002-v6.1,

document control dated this version (6.1) as March 2018. We have reviewed this policy. Although depot medication is not mentioned specifically, in the section on Transfers and Transitions (4.14), the policy describes a range of potential transfers including to other services, and describes the essential information to be shared, including risk and details of medication and states “In response to the needs of individual service users and the service, the transfer process will be initiated following discussion and care plan review with the multi-disciplinary team members, service user and carers. It is the responsibility of the care co-ordinator or lead professional to co-ordinate this and planning should involve all relevant members of the multi-disciplinary team and other services or providers of support. Any referral made to an external or internal service should clearly indicate the level of urgency”.

2.73 We have seen evidence of an audit of transfers to ensure adherence to policy.

2.74 We have accordingly graded this as ‘C’, sufficient evidence to demonstrate completion.

2.75 The internal action plan records that “Audit of Referral documentation to ensure the timescale within which the patient will require clinical contact is clearly defined” and “CPA policy to be updated to reflect this requirement”. These actions are recorded as completed, and that “external/ internal referrals to other services are monitored via daily huddle process”.

2.76 Similarly, we have also seen that the Admissions, Discharge, Transfer Policy has also been revised and now includes the following text.

2.77 “It is the responsibility of the care co-ordinator or lead professional to co-ordinate this and planning should involve all relevant members of the multi- disciplinary team and other services or providers of support.”

2.78 We have been told that these amendments have been ratified and published in the Trust policies. We have been provided with the ratified and in date copies of the CPA policy (discussed earlier) and the ‘Admissions, Discharge, Transfer Policy’, version 7.1 dated September 2018, which includes details of the staff involved in its development.

2.79 We have accordingly graded both these recommendations as C, complete. In order to demonstrate completion of this action the Trust now needs to provide evidence of a revised policy with full ratification.

2.80 To demonstrate embeddedness and impact of this change to policy the Trust should then audit referrals made to ensure that overdue depot medication and urgency is included in all referrals (internal and external).

3. OVERALL ANALYSIS OF ACTION PLAN

3.1 The overall conclusion of the review is that all six of the recommendations are complete.

3.2 We are unable to give full assurance of embeddedness and impact (i.e. Grade A) for any recommendations.

3.3 We recognise that many of the actions will take much more time to become embedded practice.

3.4 The overarching concern of the independent investigation report was focussed on monitoring medication for people in contact with EIP, that EIP services received consistent medical input to help monitor anti-psychotic medication and that the urgency of need was communicated clearly in referrals (both internally and externally).

3.5 Whilst these service changes are now in place, in order to fully demonstrate that the services have changed practice and it is embedded, the Trust should provide further robust evidence of the changes to practice as discussed in this report.

Appendix A – terms of reference for the independent investigation

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

- Review the progress that the trust has made in implementing the action plan.

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from Mr S's first contact with services to the time of his offence.

- Review the appropriateness of the treatment of Mr S in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.

- Review the adequacy of risk assessments and risk management, including specifically the risk of Mr S harming himself or others.

- Examine the effectiveness of the Mr S's care plan including the involvement of the service user and the family.

- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

- Consider if this incident was either predictable or preventable.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.

- Assist NHS England in undertaking a brief post investigation evaluation.

Supplemental to Core Terms of Reference

- Conduct an evidence-based review of whether previous independent report recommendations have been fully implemented.

- Support the commissioners (CCG) to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.

- Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CCG and Trust and feedback the outcome of the assessment to NHS England North.