2008

LEARNING FROM EXPERIENCE

Report of consultancy to support the compilation and analysis of learning from the 2002-2006 London mental health homicide reviews and analysis

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Table of Contents

The project brief

The NHS is required under Health Service Guidance (HSG (94) 27) on the discharge of mentally disordered people and their continuing care in the community and the updated paragraphs 33-36 issued in June 2005) to commission an investigation when a person who has recently been in receipt of mental health services for six months or more commits a homicide. In the years 2002 to 2006 there were a total of 69 reported cases of homicide carried out by mental health patients in London. Not all of these fulfil the HSG criteria, but many do. When it was established in 2006, NHS London inherited a number of internal investigation reports and ongoing investigations from the former London SHAs.

NHS London has managed this inherited workload by commissioning a review to determine: those cases that could be closed; those requiring further work, including independent review; and the themes that have emerged from each of the investigations. It is considered vital, not only that the learning from the reviews of these incidents be established but that it be shared and embedded in practice to minimise the risk of mental health homicides in London, and further a field, in future.

NHS London sought tenders to enable it to commission an organisation to extract, analyse and thematically collate in report form all learning points from the investigations and reviews that will have been completed on behalf of NHS London or the commissioning PCTs by January 2008. Additionally NHS London has commissioned a parallel piece of work on the investigation of 25 cases which will be completed to the same timescale. It is expected this work stream while separate will inform the learning exercise that is the subject of the tender and NHS London will require the work streams to communicate in such a way that this objective is met.

The objectives of this exercise will also need to be delivered in such a way as to support subsequent work on:

- action planning for the embedment of the learning and recommendations in practice; and
- the development of tools for this purpose.

More specifically the tender document stated the scope of the project in the following terms:

> *"SCOPE OF SERVICE*
>
> *The objectives of this exercise will also need to be delivered in such a way as to support subsequent work on:*

- *action planning for the embedment of the learning and recommendations in practice; and*
- *the development of tools for this purpose*

Project timescale

It is aimed to complete the project report by 31st March 2008.

Project deliverables

It is planned that completion of the project will result in a report, suitable for publication, to cover:

- *All key areas of remediable practice;*
- *Suggested quality criteria for future service commissioning;*
- *Suggested KPIs for performance managing quality of care;*
- *Discussion of findings from a service user perspective;*
- *Discussion of findings in the context of national and international research and best practice guidance in this field;*

- *Development of these outputs should bear in mind that subsequent phases of the project will aim to produce:*

- *Recommendations on practical ways to put this learning into every day practice;*

- *Tools, to include*
  - *A guide for practitioners on best practice*
  - *Audit tools for local and central use*
  - *Resources suitable for web-based accessibility – guidance, templates, audit tools etc.*

Awareness-raising

Conference event(s) to raise awareness of the report's findings and recommendations
Action plan for the establishment of website access to practice development resources".[1]

One impression that may be gained from reading this report is that many things went wrong and few things worked. This impression would be mistaken, many of the Inquiry reports commend examples of good practice they found in the course of their work. As the tender document specifically asks for a report to '*cover all key areas of remediable practice'* we have concentrated on the problems identified in Inquiry reports. Future development work in later stages of this project such as '*a guide for practitioners on best practice'* would redress the balance.

[1] London SHA: Tender for the provision of consultancy to support the compilation and analysis of learning from the 2002-2006 London mental health homicide reviews and analysis Reference: PA/AD- 02 dated 30 January 2008

Methodology

This project has considered the objectives listed above in a short period of time and the broad pointers for future commissioning, performance indicator development and audit and clinical governance should be measured against this.

An initial discussion of the project brief lead to the view that the emphasis of the project was firmly based on how the incident findings and recommendations should be looked at within the context of commissioning, providing and auditing. The project team began by reading the Inquiry investigations in their entirety and began a process of extracting what were seen as 'issues' by the Inquiry panels themselves. We then tried to identify how frequently issues were mentioned and were then used to form recommendations.

It was also essential to read the reports in relation to each other, in the sense that it was possible that some panels would raise concerns which would be mentioned at all by other panels, for instance, services were not available at the time or the panel appeared to be unaware of policy developments elsewhere such as Multi Agency Public Protection Arrangements. The terms of reference given to Inquiry panels vary considerably and the format of reports varies as well. It should be noted that over the four year period under review that overall the quality and timeliness of content and analysis improved. The development of Root Cause Analysis has enhanced the process and should be seen as a welcome and positive development. The depth of our inquiry was also affected by the fact that there is only an internal inquiry report available in the majority of cases – 26 out of 40 cases. In a small number of cases there is only a summary of the Internal inquiry report.

Once we had completed this form of contents analysis, it was possible to aggregate many issues into a set of higher order themes which could then be used as the basis for drawing up a list of 'key areas of remediable practice' which could in turn be looked at from the perspective of a commissioning body. We were then able to describe these key areas from a provider's perspective before generating key performance indicators that could be used to monitor the providers' performance.

We also studied the recommendations made by External Inquiry panels as these often contained more highly focused comments on the provison of services than the narrative parts of the reports. It is also important to point out that many of the Internal Inquiry reports had positive comments about staff behaviour and practice. Trust policies had been followed, services communicated fairly efficiently and clinical practice was appropriate; however, many of the Internal Inquiry reports told a different story but were not sufficiently critical to trigger the commissioning of an external inquiry.

We have also been able to bring to bear a certain amount of corroborative information to support the 'key areas of remediable practice' which we have identified. The report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[2] includes information on factors which could have made homicide less likely in cases as assessed by clinicians where individuals had been in contact with mental health services. The Healthcare Commission publishes an annual User Survey based on questionnaires given to patients in each NHS Mental Health Trust. The questionnaire covers a wide range of topics including contact with mental health professionals, service user involvement in the Care Programme Approach, access to emergency services and relationships between mental health professionals and carers.

Demographics of the cases

The project team knew that some 69 serious untoward incidents had been reported on over the years under review and that it was important to describe the sample of 40 cases they had been allocated. Information was available from 30 Internal Investigation Reports and 11 External Inquiry Reports. Establishing some of the demographic characteristics of the sample seemed to be an important starting point. There is no implication that these characteristics in some way caused the incident; nor are we making any claims about the representativeness of the group of cases as we have no comparative data on the people who used mental health services in London between 2002 and late 2006.

Age at time of incident

The 30 men and 10 women in the sample of cases and their ages can be seen in the table below.

Age groups	Males	Females	Total
20-24	6	1	7
25-44	13	5	18
45-64	7	2	9
65-74	1	0	1
Don't know	3	2	5
Total	30	10	40

[2] L. Appleby et al (2006) *Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Health – Avoidable Deaths*, Department of Health

The majority of the individuals involved were under 44 years of age at the time of the incident (25 out of the 35 cases where their age is known). This is true of the men and women in the 'sample'. The average age of the males in the sample at the time of the homicide was 37 years while the comparable figure for the women was 36 years.

It is worth noting that in 5 of the 40 cases it is impossible to find any information relating to the age of the individual concerned.

Ethnic group

In order to facilitate comparisons with other descriptive materials we have used the ethnic group categories used by the Office of National Statistics but we are reliant on this information being recorded, and recorded accurately in the first instance.

	Number
White	
British	15
Irish	1
Any other white background	3
All White groups	19
Mixed	
White and Black Caribbean	1
White and Asian	1
Any other Mixed background	1
All Mixed groups	3
Asian or Asian British	
All Asian groups	3
Black or Black British	
Caribbean	8
African	2
All Black groups	10
All ethnic groups (including White)	35
Not stated	5

Note: the groupings used here follow those used by the Office of National Statistics

Information on the ethnic group of the individual was recorded in 35 of the 40 cases and it can be seen that the largest single ethnic group was 'White', followed by 'Black or Black British' with 10 individuals, the 'Mixed' group and the 'Asian' group contributed three cases each.

Clearly we cannot assess the accuracy of the information that has been recorded but it is a matter of concern that basic monitoring information such as age and ethnicity is not available in all cases. Some Trusts include date of birth and ethnicity as matters of routine on a proforma front page of inquiry reports but others do not as the format of Inquiry reports varies from Trust to Trust.

Accurate and complete data on gender, age and ethnicity are essential to good quality commissioning at a strategic level given research findings from the Sainsbury Centre for Mental Health. The Sainsbury Centre for Mental Health stated in 2006 that the population of the London population was 71% White, 12% Black and 17% Other according to the 2001 Census. But these broad categories conceal important differences in the composition of ethnic groups, so that greater proportions of the Black and Other groups are aged under 25 than is the case for the White group. Consequently, a much greater proportion of the White group are in the 50+ age groups. The BME population of London is not evenly distributed across the area. The SCMH found in their study that the four Trusts which provided data made up approximately 43% of the total population of London but included 60% of the Black population. They argue that a Black person is around 1.6 times more likely to come into contact with mental health services in London than a White person. This figure goes up to 2.9 when the Black experience of in-patient care is considered. Black people in the catchment area of the sample trusts have nearly twice as many CMHT contacts per head of population as their White counterparts. This increases to six times as many contacts with assertive outreach services.

Black people are more likely to have been referred to inpatient services by the police or the courts than by their GP. They are also more likely to be secluded or physically restrained than their White counterparts. The most significant difference in service use emerged in the SCMH's analysis of psychiatric intensive care and medium secure units. In these sectors, Black people were seven times more likely to be admitted than their White counterparts[3].

We know a considerable amount about the over-representation of Black people as mental health service users but it is also clear from our reading of Inquiry reports that members of Asian communities can have their needs neglected by service providers. The phrase '*we don't do one offs'* (a phrase used in one report) means that some individuals rarely if ever get the opportunity to discuss their situation in their own first language. Service providers, in some institutions appear to make a limited attempt to understand mental illness in the service users' culture and community of origin. It is perhaps surprising that in the light of all the comments London's cultural diversity, some individuals have little support from or contact with their

[3] Sainsbury Centre for Mental Health (2006) *The Costs of Race Equality*, London: Sainsbury Centre for Mental Health Policy Paper 6

linguistic and/or cultural community. Some people can be very isolated if they happen to live in a Borough at some distance from a vibrant community of their peers. Local mental health services give the impression of responding to large or well organised ethnic communities.

A further complicating feature of the London population is the extent of internal migration. The Office of National Statistics publishes data on the local government areas with the highest population turnover. In the period 2001-06, the ONS found that 22 areas had between 18 and 28 moves per 100 population, of which 18 were London boroughs. The City of London had the highest figure for a London local government area at 28 moves per 100 population, followed by Westminster with 26 and Camden with 24. (Cambridge has the highest average volume of migration at 28 moves while Oxford has 26.[4])

Reasons for initial contact

The reasons for these 40 individuals coming into contact with mental health services in the first place are varied as can be seen in the next table. It is often proved difficult to find a clear statement of a diagnosis made on initial contact and there were many cases in which more than one diagnostic label was given.

Reasons for initial contact with mental health services	Times mentioned
Drug misuse	7
Depression/severe depression	6
Aggression/violence/anger management	5
Psychosis/psychotic ideation	4
Alcohol abuse	3
Drug induced psychosis	3
Schizo-affective disorder	3
Paranoia/paranoid schizophrenia	2
GP referral to CMHT	2
Transfer under s 48/9 MHA	2
Personality disorder	2
Anxiety	1
Obsessional compulsive disorder	1
Adjustment disorder	1
Manic-depression	1
s.177 aftercare	1
Suicidal/ likely to self-harm	1
Total reasons mentioned	45

The figures in this table are based on 39 cases. In the remaining case no reason for initial contact is given.

[4] Office of National Statistics (2007) *Population Trends*, Winter, No 130, p. 10

The single most frequently mentioned reason for initial contact with mental health services was 'drug misuse', with 7 mentions. It should be noted that there were also 3 mentions of 'drug induced psychoses'. The drugs mentioned most frequently are crack cocaine and cannabis. There are a further three mentions of chronic dependency 'alcohol abuse'. The grouping of 'aggression/anger management/ violence' needs little explanation but it includes cases where the police had been called to conflicts between neighbours. It is possible that a skilled reader of the original case files might come to different conclusions about reason for initial contact or they might reduce the number of categories as those mentioning psychosis might overlap. Several homicides occurred in Bed and Breakfast/Hotels for transient populations in which service providers had been placed by Homeless Persons Units.

Time in contact with mental health services

In order to understand the findings it is useful to have some idea how long the individuals involved had been in contact with mental health services. It is often difficult to give a precise start date for first contacts with mental health services as inquiry reports often state a month and year. The nature of the problem of trying to reduce homicides committed by people who have been in contact with mental health services could be vary if it were to be established that most homicides had been committed by people in the first few months of contact with mental health services.

Time interval between first known contact with mental health services and incident which triggered report	Number
Less than one month	2
1 month but less than 3 months	2
3 months but less than 6 months	1
6 months but less than 12 months	2
12 months but les than 2 years	9
2 years but less than 4 years	3
4 years but less than 10 years	7
10 years or more	10
Not known	4
Total	40

Seven of the individuals in our 'sample' of homicide cases had been in contact with mental health services for less than 12 months. In the two cases in the 'less than one month' category the individuals concerned made contact with the mental health service once, via the self-referral Drop-in Service, and killed three weeks later. In neither of these cases was there anything other than the initial contact. The majority of the cases involved medium and long term contact with

mental health services. One of the principal reasons for looking at time in contact is that lack of time to understand the individual and his/her needs may be related to the outcome of the case. But in most of these cases it seems that there had been plenty of opportunity for assessment to be carried out.

Main care provider at time of incident

One area of possible concern about homicides committed by people who have been in contact with mental health services is that of which organisation was providing treatment or care (no matter how notional) at the time of the incident. Informal discussions have lead to comments about the primary system being unable to cope with mental health issues. Media reports tend to stress cases of failures in inpatient provision. No claims are being made here about the representativeness, or otherwise, of these figures as we do not have any way of knowing how many people are in contact with GPs as opposed to CMHTs or other community based services as opposed to being inpatients.

	Number
General Practitioner	9
CMHT	12
CMHT + supported housing	1
CMHT + residential care home	1
Assertive outreach team	2
Assertive outreach team + psychiatrist	1
Drug service	1
Early Intervention Service	1
Psychiatric hospital inpatient	2
Outpatient	2
Medium secure unit	1
Residential home	1
High security hospital	1
Walk-in service	1
Primary care/ mental health/ maternity services	1
None, CMHT did not offer service	1
None, discharged	2
Total	40

The great majority of the individuals in this ‘sample’ (37 out of 40) were in some form of contact with the mental health services, even if they were not responding to appointments etc. GPs were the main provider of care and treatment in nine cases. CMHTs, in one form or another,

were involved in 14 of the cases; in association with supported housing and a residential care home in a further two cases. Assertive outreach teams had contact with only three individuals; this probably reflects the early stage in the development of assertive outreach at the time these cases were in contact with mental health services. The same is true of the one individual in contact with an Early Intervention Service. Only one individual had been refused service as his case had been sent to a CMHT and its staff decided not to offer a service.

There were many permutations and combinations of care and treatment experienced by many of the individuals who make up this group over the time they were in contact with health services including mental health services. This reinforces the information provided in the table on length of time in contact with mental health services. Very few have had limited contacts, the majority have had years of contact although in may cases the level of contact was minimal as a result of the individual's disengagement from mental health services or because they had been discharged for failing to attending appointments.

Relationship with the victim(s)

Media representations of homicides committed by people with histories of mental illness which make the headlines concentrate on stress unprovoked attacks on total strangers. We have collected information on relationships with the victim(s) which is presented in the next Table.

	Number
Subject acquainted with victim	
Son or daughter	4
Parent	3
Partner/ ex-partner	4
Other family	-
Friend/ acquaintance/ neighbour	7
Fellow patient/ resident	4
Sub-total	22
Subject not acquainted with victim	
Stranger	15
Relationship not known	3
Total	40

This way of classifying victims follows that used in Home Office statistics on homicides as published in the annual Criminal Statistics

In 22 of the 37 cases where we have information about the relationship the subject was acquainted with the victim(s). In 11 of the cases, the victim was closely related – son or daughter, or parent, or (ex)-partner. In the other 11 cases in the sub-group, the subject knew the victim to some extent as a friend or acquaintance or as a neighbour in 7 instances while the

subject and their victims were fellow patients or fellow residents (in hostels or supported housing).

In 15 out of the 37 cases where there is information, the subject and the victim were unacquainted and the victim seems to have been chosen at random in a public place. In two cases the homicide was the outcome of a street robbery where the victim may have resisted to some extent and was stabbed.

Diagnoses made by Inquiry panels

One of the tasks that Inquiry Panels take upon themselves is to try to come to a considered diagnosis of the individual in order to evaluate the care and treatment given by the NHS Trust. The evidential basis on which they come to these conclusions is very mixed especially when the individual has had limited contact with mental health services, or that individuals have practiced concealment when in contact with mental health professionals.

Diagnosis made by inquiry panel	Number
Psychosis	9
Psychosis – drug induced	2
Schizophrenia	4
Paranoid schizophrenia	3
Paranoid psychosis	3
Bi-polar disorder	2
Personality disorder	2
Drug dependency / poly substance abuse	2
Personality disorder + alcohol abuse	1
Personality disorder + poly substance abuse	1
Adjustment disorder	1
Cluster B personality traits	1
Depression	1
Depression with psychotic features	1
Depression + personality disorder + alcohol abuse	1
Delusional disorder	1
Frontal lobe epilepsy	1
Organic factors	1
Post natal depression	1
None given	2
Total	40

The single most frequently mentioned diagnosis made after the incident is psychosis (9 cases) followed by paranoid psychosis (3 cases) and drug induced psychosis (2 cases). Schizophrenia and paranoid schizophrenia make up a further 7 cases. Although substance abuse is rarely mentioned as the sole diagnosis, it is clear from this table that alcohol and drug abuse are

important contributory factors, aggravating existing mental health problems. Drug and alcohol abuse feature prominently in the narrative accounts used by Inquiry panels.

NHS Trust commissioning report

NHS Trust	Number
Barnet, Enfield and Haringey Mental Health NHS Trust	4
Camden and Islington Mental Health and Social Care Trust	4
Central and North West London Mental Health NHS Trust	1
East London and the City Mental Health NHS Trust	7
North East London Mental Health NHS Trust	3
Oxleas NHS Foundation Trust	1
South London and Maudsley NHS Foundation Trust	10
South West London and St George's Mental Health NHS Trust	8
West London Mental Health NHS Trust	3
Total	41

This total exceeds the number of cases because in one of the cases, one NHS Trust commissioned an internal inquiry report while a second Trust commissioned the External Inquiry as the case involved 3 or 4 Trusts and three local authorities. This raises the important point in relation to commissioning mental health services in London, people cross geographical boundaries and access services in ways which expose the area-based nature of the services. The most extreme example we found involved two NHS Trusts, a PCT, a borough Social Services Department, and a County Council. One Mental Health NHS Trust provided intermittent care for 30 months (before the individual moved to a privately run mental hospital); the same Mental Health NHS Trust and a Social Services Department were involved in the commissioning, placement and ongoing Care Management while in the private hospital; a second NHS Trust was involved as the private hospital was in their service provision area and a consultant from the Trust provided a service to the private hospital; a County Council had responsibility for the protection of vulnerable adults as the private hospital was in their catchment area; and, a PCT commissioned the health element of the individual's placement in the private hospital. A third NHS Trust was involved in placing and monitoring the victim's care and treatment whilst in the private hospital. After the homicide the complications continued with four (old-style) Strategic Health Authorities having an involvement in the inquiry processes as the various NHS Trusts fell within the geographical areas. The Healthcare Commission was also involved as the responsible body for the inspection and registration of the private hospital.

Post incident history

It is not always clear what has happened to the individual after the homicide incident largely because the majority of investigation reports are internal and the legal process was still on-going at the time of writing. This has a number of consequences in that it is not always possible to discover what has been done to de-brief staff, or whether family and friends of the victim(s) have been contacted by the NHS Trust staff, or whether family and friends of the service user have been contacted. Occasionally, media reports of incidents and subsequent court proceedings are attached to the Inquiry report.

To the best of our knowledge 16 of the subjects of the Inquiries were prison either on remand or post conviction. Thirteen were in either medium or high security hospitals. The location of six was not stated anywhere in the reports. One had fled the UK and another was deceased by their own hand.

Historical problem

One of the issues that struck the project team early in the review process was that the incidents being reviewed were spread over a lengthy period, the earliest being January 2002 with the latest dated December 2006. The authors of individual reports often note how much has changed between the incident they are reporting on and the time they are completing their report. Some of the changes reported are organisational e.g. one Mental Health Trust was formed from the disaggregation of three community service trusts and the merger of their mental health services to create a new organisation, or the Social Services Inspectorate became the Commission for Social Care Inspection in April 2004 At the same time there have been changes in the way mental health services have been provided, inspected and their performance assessed e.g. the increasing number of specialist forensic staff, or data that had been reported to the DH was later also monitored and managed by the SHA, or the CHI had metamorphosed into the Healthcare Commission.

There is also the problem of producing a document for the London SHA which will have impact on the work of the 31 PCTs which will be commissioning services from the 10 Mental Health Trusts in the London area. The problem is that many may not identify with the issues that are raised below; their response may be that it all happened long ago or far away, or both. Indeed this problem has been recognised by many of the review panels – that things had changed and what had appeared in the course of the investigation could not happen now. In their case, 'now' meant 30 or 36 months since the incident. The other response which is peculiar to our task of a London-wide review is that some might argue that events might take place elsewhere in the metropolis but not on their patch. We have sought to overcome these problems in the same way

as was done by several of the review panels, by reference to the Patient Surveys published annually by the Healthcare Commission. Policies and initiatives may have proliferated but not all have been apparent to the recipients of services.

It is clear from the inquiry panel reports that policy and practice diverge in many cases and consequently tragedies have occurred. A number of inquiry reports state for example, that if the CPA had been in effect at that point in time then the outcome might well have been different. But it is clear form contemporary comments that even though the CPA has been in effect since 1990, its implementation has been patchy and rarely as policy makers intended.

Reference is made in many of the reports in our sample to service users persistently failing to attend appointments and being discharged from caseloads as a result. Many of these examples predate the establishment of Assertive Outreach Teams and this approach would now be seen as the most appropriate means of managing this type of service user. What is not clear is whether the subjects of the Inquiries would have responded to kinds of approach employed by Assertive Outreach Teams. It is not clear how effective Assertive Outreach Teams are with difficult non-responsive service users. Some of our Inquiry subjects were described as actively resisting treatment interventions through non-compliance with medication, or through using alcohol when they knew that staff would not give medication to some one who had been drinking.

In a significant number of cases there were comments about the records and systems of record keeping. The comments included the illegibility of hand written notes, the absence of signatures, failure to record decisions or the reasons for decisions, on occasions records were not available to all the staff involved in caring for an individual or private records were kept in separate formats from the wider Trust record system. We are not clear how far the London Integrated Mental Health Electronic Record Project has solved any or all of these problems.

Key areas of remediable practice

Our reading and analysis of the 40 Inquiry reports have generated a large number of failures in the practice of the primary, secondary and tertiary care organisations involved. Some are comparatively frequent in occurrence while others are rare. Unfortunately, rare does not mean inconsequential. We believe that these areas are remediable but they require action at all levels of care. Specialist provison in the form of CMHTs and in-patient wards have been the main focus of our attention as this reflects their current, and key, place in the organisation of care and services for mental health service users. GPs need significant support and consistent communication concerning their patients, use of repeat prescriptions, patients' long term vulnerability and regular review of those patients with the managers of CMHTs. A few GPs were badly neglected by these systems. Forensic services, apart from what was often described as financial constraints placed on the referring unit for opinions, appeared from the reading of the Inquiry reports to be distant and apart from the main stream services. For example, when the event such as homicide occurred assessment was offered once the alleged perpetrator was remanded. The Inquiry reports gave little idea that there were strong links with forensic services and that protocols may, if in existence, need to be strengthened. The only example of a referral format for a forensic assessment seemed to deter the referrer by the plethora of information required.

Having made these broad observations we have to state that they could not be tested to their final conclusion, although it should be noted that some were not as thoroughly tested by initial internal Inquiry but only upon external review.

We have grouped these key areas of practice into six broad categories – strategic issues which cover issues such as finance and staffing; initial contact and referral; diversity/ethnicity issues; initial referral and contact – how the initial contact between an individual and a mental health service works or fails to; experience as an in-patient; the care programme approach; and risk assessment. As is apparent, some of these issues overlap and interact.

Strategic issues

- What happens to service users when Trusts are under severe financial pressure and have to reduce use of agency and bank staff who are providing supervision?
- Is mental health legislation used appropriately and knowledgeably? How capable are the staff who represent the Trust before Tribunals and other decision making bodies? Lack of training to understand dual diagnosis and personality disorder.

- How are levels of forensic services or psychological treatment decided by the Trusts? How is access to these services decided locally?
- Are there policies about the employment of locum consultants and how they are trained in Trust policies and inducted into the knowledge base of available services and resources?
- Lack of agreement about levels of staff permitted to make decisions such as discharge from different components of service (e.g. SHO, specialist registrar or consultant or nurse).
- How robust/effective are Trust risk assessment policies?

A number of issues emerged from Inquiry reports which could only be addressed at Board or Director level. A common feature underpinning several is resources. One Trust in particular was facing severe financial difficulties and had to reduce expenditure very quickly. One way of doing so was to terminate the contracts of agency and bank staff on a chosen date. Some of the agency staff were employed as CPA nominated key workers, a role considered central to the effective treatment of service users, and consequently some service users were left without a CPA coordinator. Senior managers were warned that some problem service users would be left in this position but they did not seem to have inquired too aggressively about the level of risk posed by this withdrawal of supervision and support.

An abiding impression from reading these Inquiry reports is that Trusts rarely lack policies on the issues identified by these cases but what they do lack are the processes of implementing the policy in terms of making training available and then checking that all staff apply the policies in the ways intended. Policies are rarely self-enforcing; training and auditing are resource intensive.

There is also the matter of staff appointments and recruiting at consultant level which again are matters of Trust policy. The practice of routinely operating a service with consultant level vacancies or with locum consultants who may not be given any induction training in Trust policies seems a high risk strategy. It is not clear whether the two points are directly related but we found instances of comparatively junior members of medical staff making decisions about discharge, for example, which ran counter to Trust's stated policies, the Code of Practice and the Mental health Act 1983. Are consultants with the appropriate skills being employed for example, someone with experience of working with people with histories of violent and/or challenging behaviour. Consultant staffing vacancies should be included on the Trust's risk register and the level of risk involved reviewed regularly.

Diversity / ethnicity

- Failure to provide culturally competent aware service for all segments of community.
- Failure to provide services for non-English speaking members of the community.
- Failure to utilise support from ethnic community and voluntary sector organisations.

The issues here as government policies in relation to ethnic minority communities evolve; the idea of providing services in languages other than English is falling out of favour. We recognise that such services may be of limited duration, to provide services for an older (probably first generation) migrant community whose children are English speakers. It seems to us that the provision of written material on mental health issues is a good practice as information using unfamiliar English terms may be difficult to comprehend during times of stress and will help Trusts meet their requirements to provide equal access to health services. The Mental health Act provides an excellent example by producing information and guidance in written form in many languages including Welsh.

Initial referral and contact

GP Issues

- Failure of GPs to understand their role e.g. as acknowledged care leads?
- GPs lack knowledge of MHA and assessment rights and requirements, carer assessments and monitoring of vulnerable adults via regular review.
- Failure by GPs to state clearly reasons for referral (e.g. Adult Protection).
- Repeat prescription reviews.

There are numerous examples in the group of Inquiry cases where the initial contact as initiated by the GP has not worked as planned and nothing has worked thereafter. The crucial point seems to be GP understanding the requirements of the Mental Health Act 1983 and being able to present their concerns about a service user in such as a way as to fall into categories that a CMHT will recognise and engage with. There were a number of cases where there was mismatch between the expectations of the two sides, so access to secondary services were either denied or delayed. Joint training and/or training for GPs in mental health issues might be worth pursuing especially with the changes proposed in the new CPA.[5]

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[5] Department of Health (2008) *Refocusing the Care Programme Approach - policy and positive practice guidance*, London: Department of Health

Initial contact

- Staff making initial assessments lack the information on which referral was based.
- Switch board mis-directs call from GP for ASWs to CMHT.
- Complicated contact or access processes when in crises.

Some attempts by GPs to make contact with CMHTs look more like farce than the smooth seamless services that might be expected. The apparently simple task of getting through the switch board to the right people depends on the skills of switch board operators as well as callers. Some Inquiry reports give an image of complex procedures which discourage or even prevent access. There are also cases in which decision making was hindered by the non-availability of an approved social worker to carry out an assessment when the service user arrived late for an appointment.

Quality of CMHT decision making and communication

- Lack of clarity about how CMHTs make decisions in respect of case management, allocation matched to staff competencies and experience, closure and communication of actions.
- No notes taken of decisions made by CMHTs or notes illegible.
- Poor quality diagnosis.
- Lack of clarity about CMHT processes e.g. how are patients allocated to a consultant by CMHT, how are consultants informed of CMHT decisions, what process is followed if consultant is on leave?
- Failure to record notes of assessments or plans on records or computer systems or only on local system (wrong address meant outpatient clinic appointment sent to wrong person).
- Appropriateness of staff making judgements about mental illness (only medic can legally) but social workers are also used, need for specialist input e.g. neurological or forensic.
- Lack of continuity of referrals i.e. to CMHT where there has been previous contact?
- Staff ignore statutes other than mental health e.g. vulnerable adult or disabled adult, and hence entitled to services.

The quality of many initial contacts is regarded as poor by Inquiry panels because insufficient information was collected or not recorded in ways that were comprehensible to late investigations. The impression is given that initial assessment were carried out quickly with decisions made on limited information, occasionally based on misapprehensions as to why the

person had been referred in the first place with the primary aim being to decline offering a service unless the individual met very obvious but limited mental health criteria.

Ward management - inpatient care

Diagnoses / recording and note keeping

- Absence of recordings from medical notes – basis of and outcome of decisions. Appointments recommended but no record of invitation being sent.
- No clarity of diagnosis.
- Absence of a Health Records Management Policy on unified inpatient case-notes/ poor quality record keeping.
- Non-compliance with NHS Litigation Authority standards to promote continuity of care and to prevent loss of documentation.
- Failure of consultants to read case notes.

The sorts of comments made above on initial contacts with CMHTs are replicated on entry to a hospital ward as an inpatient. Inquiry panels found it difficult to find comprehensive sets of notes which were legible and signed. Often diagnoses were described as being unclear. In one case, some six different diagnoses were offered during the time the individual was in contact with mental health services. Even when case records are made in the prescribed format in compliance with Trust policies there is no guarantee that they will be read by ward staff, including consultants

Ward management

- Complexity of ward organisation – separating consultants from nurses doing day to day work with patient.
- Lack of active intervention on ward e.g. just warehousing; or control of illness through medication only.
- Failure to police alcohol ban not breathalysed routinely as directed by medic.
- Failure to challenge sexually ambiguous / inappropriate remarks.
- Failure to confront/challenge when agreed risk indicators are observed e.g. missing appointments and drinking).
- Failure to challenge violence and or aggression.
- Failure to protect patients from bullying.
- Lack of procedures to follow up patients who abscond or absent themselves.
- Poor access to forensic assessment and/or interventions.
- Poor access to psychological assessment and/or interventions.

At a time when inpatient facilities are under pressure it is surprising to read that "The Consultant and team on …… did not indicate any active treatment, either psychological or pharmacological, during the period .. of nearly three months that .. remained on the unit". There are also examples of staff not reading patient's notes and consequently not appreciated the risk they posed.

Information sharing

- Lack of availability of records to A&E staff or other gatekeepers.
- Absence of information sharing protocols, misunderstandings of confidentiality requirements.
- Failure to involve community team during spell as in patient and subsequent reduction of scope of risks assessment.
- Issue of addressing information to right GP in multi GP practice.
- Clarity of medication plans and communication to others such GPs.

Once again information is a major issue, its collection may have been imperfect but its distribution and sharing with others is more problematic. There are persistent misunderstanding about confidentiality and a lack of working knowledge of the protocols on information sharing that do exist. Staff rarely seem to have any perception of being engaged in a common enterprise centring on the care of the individual. The notion of 'a duty of care' to other people coming into contact with a potentially violent or abusive service user does not seem to exist. Real or imagined confidentiality requirements invariably outweigh the duty of care. The number of simple errors in communicating between hospitals and GP practices is not surprising given the amount of traffic generated in hospitals but good treatment and care can be totally negated by letters going to wrong GP.

Risk assessment and management

- Failure of risk assessments to include views of other disciplines such as OT.
- Failure to inform all ward staff of level of risk posed by patient.
- Lack of staff competence to deal with personality disorder.
- Lack of access specialised psychological services by in patient and CMHT.
- Failure to note previous history of sexual relationships with women in same units.
- Lack of clarity in observation and seclusion policies.

One of the recurring points about risk is the way in which risk assessment and management is compartmentalised. Assessments are frequently made on the basis of limited information, from a range of sources which often excludes those in daily contact with the service user (i.e. ward staff). Information about the risk posed by a service user is sometimes not communicated to all

members of ward staff and they have gone on to put themselves in dangerous situations. There seems to be a very limited repertory of treatments (psychological or forensic) routinely available to reduce risk. Treatment seems to be almost exclusively medication based.

Use of MHA on discharge

- Poor use of MHA requirements i.e. failing to use Section 17 leave.

Hospital managers who have the task of deciding on discharge complain that they are pushed into agreeing to absolute discharges when the safer option would be a conditional discharge, so that compliance with medication etc could be monitored more effectively.

One of the scenarios common to many of the Inquiry reports is that of the individual service user becoming an inpatient for a period of time during which the intensity of their symptoms is reduced. It is not always apparent whether this reduction comes about as a result of medication or through a reduction in the stressors in their environment outside. At that point, the individual is discharged and quite frequently this process happens at some speed and arrangements for support in the community are often vague and untested. In a matter of months the individual's condition deteriorates either through unwillingness to take medication or through a return of various stresses and strains. The individual may come back to in-patient treatment if they or their GP can trigger the access to care processes in the right way. In-patient treatment episodes seem to aim at stabilisation rather than recovery as proposed recently by Shepherd and colleagues at the Sainsbury Centre[6] as the main rationale for mental health services.

Care Programme Approach

Without doubt the Care Programme Approach, the central plank of government strategy for the development of systemic delivery of care and management of mental disorder, according to many of these reports, has either not been consistently enacted, or, at worst, been ignored. As this approach has been introduced and developed since 1990, reviewed and more recently modified to focus more on those service users deemed to have ever increasing complex needs it does not auger well for the future if this process is not rigorously pursued at all levels of practice and audited.

If one area is of paramount importance to commissioners, provider units and their managers then the Care Programme Approach is it. If there is a policy and procedure underpinning this

[6] Shepherd, G., Boardman, J. and Slade, M. (2008) *Making Recovery a Reality*, London: Sainsbury Centre for Mental Health

expectation then it should be followed. The Care Programme Approach is supported by all professions and so the question needs to be posed – why does it not work consistently. Over-bureaucratisation may be one aspect and lack of drive to see it through another. Soon there is likely to be test cases following a homicide when it can be demonstrated that the Care Programme Approach was not followed by the Trust, who consequently may lay themselves open to corporate manslaughter charges.

The relationship between the Chief Executive Officer and the Consultant Group is the keystone to the strength of this process. Consultant contracts, appraisal and personal development through continuing professional development and contribution to the audit and clinical governance associated with CPA should take precedence. If one issue of the need for consistent leadership in delivering one paramount process is required by any NHS Mental Health Trust Board then this approach demands such.

Quality of CPA process

One report noted that the Care Programme Approach had not yet been properly embedded in the Trust as a way of working (the importance of this comment is that the review period was 2002 – 2006, at a minimum more than a decade after the introduction of the Approach. There was no clear identification of key worker/care co-ordinator and in some cases the named individual did not know they had been allocated this task. On some occasions agency staff were allocated this responsibility, resulting in lack of continuity of care and handover. One example cites the appointment of four care co-ordinators in 18 months during a period of rapid organisational change. There were numerous examples of no CPA reviews being held, documentation not completed and no review date set. These were, in the judgement of the inquiry teams, a failure to place service user on the correct level of CPA (although this will change following the review of CPA).

In some instances there was little evidence in the patient file of an initial assessment or Care Plan, no initial CPA meeting having taken place or scheduled. Agreed liaison with the Police not followed up.

The role of the Care Co-ordinator was not used as the focal reference point during key changes, for example during the move to a PICU unit or upon discharge. Risk assessments were rigid and once described were not considered against changing circumstances and were not consistently transposed into a community setting. Plans to help service users with contingency plans if their circumstances changed given to them with their written care plan on discharge were sparse in the cases reviewed.

Record keeping was described in many reports as being poorly written, illegible, undated and unsigned. A multiplicity of recording systems had developed which lead to a lack of all disciplines' making assessments and contributing to care plans and discharge plans. Records were not readily accessible from different parts of the hospital.

The discharge process saw a range of no care plan on discharge, passive observation as opposed to active inquiry into mental state, premature discharge and no communication between teams when discharge from one part of the service and on some occasions no Section 117 after care planning process. The discharge decision was made by a single professional without reference to other disciplines

Discharge for non-engagement with services

Staff were unsure of how to deal with DNAs within 'Trust Discharge Policy' with no action being taken following numerous DNAs. There was poor communication with GPs after DNAs

Involvement of carers

There were major failures to work with families in order to inform them of what was happening and explaining the nature of the mental illness they may have to cope with in the future. At key planning milestones they were not included. In some cases families were denying the existence of mental illness but could not cope with the often aggressive behaviours. In one such case the lack of response to family requests for help, made on several occasions, with non forthcoming, was described by them that they "lost all our hopes". One particular case, despite pleas for cogently argued support for one carer by the family GP, when it failed to materials it resulted in that carer's death. In all reports there is a distinct lack of consideration of the benefits advocacy could have and the involvement of support networks for ethnic minority groups.

One report identified that a concerned family member was informed several weeks after the incident of homicide by her solicitor by a solicitor. This was despite her considerable involvement with one hospital although when her relative was admitted to another unit contact was lost. Any explanation of the investigative process to relatives of the perpetrator and victim(s) was lacking in some cases, although this was always attempted by external investigation teams.

Staff organisation and training

- Absence of trained and competent staff.

- Staff not organised to provide CPA – not part of their work plans or not integrated into their job descriptions.

There were several reports of hospital staff reporting that collecting information for and completing the CPA documentation was not part of their job description or that they were not given the time to complete a form which was seen as time consuming to complete, and a waste of time when it was not referred to again.

Relationships with CMHTs

- Communication between CMHT and inpatient services limited. When patient discharged from CMHT care wider service did not know.

Relationships with GPs

Advice to GPs is crucial. For example, one patient had been with the same practice for 12 years and yet there was poor advice on how to manage this young person and to explain what the risk management plan and its contingencies were. There are examples of poor consultant support to GPs and limited response to their concerns. One case saw the GP referring for anger management with the patient being referred on with no notification to the GP. There is poor communication with the GP following DNAs.

There was one example of failure to follow a simple policy when a patient was referred by a GP for an urgent visit (policy dictates 'urgent' seen within one week). The request was still under discussion 3 weeks later about when and how to visit. The killing happened the week before visit date set.

There was one example where the GP felt isolated and had developed his own risk assessment system, and this was unintelligible to his colleagues.

Relationships with Substance Misuse Teams

- Failure to use Substance Misuse Teams when service user repeatedly uses illicit drugs.
- Failure to share information with Substance Misuse Team.

This failure to involve specialist drugs treatment services seems all the more remarkable in the light of the frequency drug misuse was mentioned on initial contact with mental health services.

Relationships/ Protocols with Social Services or Other Local Authority Departments

- Failure to monitor and communicate rapid moves of accommodation - asylum seeker with housing needs met by HPU but exacerbated by paranoid ideation and multiple moves.
- Not aware child was on Child Protection Register, despite living at home. No active communication with child care service.
- No documentary evidence of Trust CPA and MBU service protocols followed re joint working to co-ordinate roles and responsibilities of each agency through agreed care programme, or effective written communication in form of detailed information made available to appropriate professionals in receiving service. No joint communication and liaison during planned periods of Section 17 leave.

Again both of these categories emphasise the problems of sharing information with third parties who are supposed to providing specialist services. Boundaries for inclusivity and exclusivity in respect of information sharing seem to be very tightly drawn, to the extent of excluding other health based services.

Risk assessment

Nature and quality of risk assessments

- Failure to carry out risk assessments on regular basis.
- Failure to investigate risk posed through collection of information from source other than service user e.g. police records, information from carer and family.
- Failure to understand the dynamic nature of risk in the community, when stress increases through illness etc of others. What happens if accommodation fails when all discharge plans are based on that accommodation?
- Lack of 360 degree risk assessments – self-harm focus rather than harm to others.
- Failure to produce risk assessments – dynamic understanding of risk – misunderstanding of risk because located in particular ward – lack of engagement with neighbours.
- Failure to evaluate history of weapon carrying.
- Failure to record violent incidents while on ward.
- Failure to complete risk assessments or poorly prepared.

- Failure to investigate sexual history or history of relationships with fellow service users.
- Appropriateness of staff making judgements about mental illness (only medic can legally) but social workers are also used.
- Lack of involvement of need for specialist neurological input to assess risk e.g. neurological or forensic services because dependent on formal legal actions as opposed to behavioural issues.
- Lack of joint multi-disciplinary working between general and forensic psychiatry.
- Failure to understand nature of risk posed e.g. is the risk posed independent of mental illness and/or dependency?
- Lack of understanding of child protection or vulnerable adult issues and policies.

The practice of making risk assessments does not seem to be embedded any more firmly than the CPA process. There is little or no evidence that staff take an 'investigative approach' to risk assessment in the sense of questioning the service user's account of incidents, failing to acquire alternative sources of information such as police reports, or to integrate ward-based observations of violent, aggressive or sexually inappropriate behaviour into risk assessments. Access to forensic assessments seems to be based on legal criteria such as a criminal conviction rather than on behaviour. It is possible that previous decisions not to prosecute were made based on mental health assessments or concerns about witnesses. In the absence of official documentation, accounts of what were serious incidents can be downgraded over the years to mere threats.[7]

Risk is dynamic and assessments need to be carried out regularly, and especially after significant changes in the service user's circumstances e.g. when given leave or on discharge or when their accommodation changes. There is also the issues of 'risk to whom', a number of the Inquiry reports spotted evaluations of risk being made solely in terms of risk of self harm to the exclusion of any assessment of risk of harm to others.

Contingency planning

- Failure to communicate relapse indicators to those in daily contact with service user.

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[7] This can happen even when there was a conviction as in the case of Andrew Robinson who was convicted of carrying a firearm with criminal intent and assault occasioning actual bodily harm but this became a row with his girlfriend as time went by. See Blom-Cooper et al (1995) *The Falling Shadow – one patient's mental health care 1978-1993*, London: Duckworth

- Lack of contingency planning – what to do if patient fails to comply with medication or other risk reducing activities, or relapse.
- Breakdowns in contact with criminal justice system e.g. charges being dropped etc.
- Failure to contact MAPPA and lack of clarity of Trust policy on referral to MAPPA.

Some of these contingency planning issue shave been referred to earlier, and will be again below, but it is important to mention the way that specialist services have been found to be operating at odds with Department of Health guidelines by not being open to service users for enough hours a day and by not having emergency out of hours contacts points.
The issue of public protection has become increasingly important in the criminal justice system since 2001 and Multi Agency Public Protection Arrangements have been established.

Overall the emerging issue is that of the psychotic patient who doesn't accept that they are ill, who conforms (just about) when an in-patient and takes some medication - gets stabilised and is released quickly into the community as ward staff can't see anything wrong with them. On release into community they slowly stop taking medication and continue drug and or alcohol use, or both. Gradually they stop attending out-patients etc, avoid outreach teams' home visits, and is then discharged from lists for non-attendance. They may be located in forms of temporary/transient accommodation. Then an unpredicted attack results in the death of a stranger in the street etc. There are significant considerations in many of these cases whereby the appropriate use of the Mental Health Act, 1983 may halt the continuing circularity of many of these patients and possibly halt the process whereby they inexorably move towards events which result in significantly lengthy periods of incarceration.

Corroborative evidence

Additional support that we have been able to identify an important set of problem areas comes from the findings of *Avoidable Deaths* (2006). In the section on homicides, clinicians were asked how many patient homicides were preventable, and additionally to identify factors which would have made the homicide less likely. *Avoidable Deaths* is based on data relating to the 2,670 homicides with a final determination between April 1999 to December 2003; most of the cases lead to conviction but there are also a small number where there was no conviction because the defendant was unfit to plead or not guilty by reason of insanity. (This time period means that very few of our sample will have been in the *Avoidable Deaths* sample.)

Clinicians identified 41 cases in contact with services within 12 months of the homicide where the homicide could have been prevented. These included 23 patients with schizophrenia, 6 with more than 5 or more previous admissions and 25 who had been previously detained under the Mental Health Act. In response to the question about identifying factors that would have made

the homicide less likely, the respondents most frequently mentioned the items shown in the following Table:

Factor	Number of cases when mentioned
Better patient compliance	59
Improved staff communication	50
Closer contact with patient's family	50
Better staff training	49
Closer supervision of patient	49
Better liaison between different services	43
Availability of dual diagnosis	30
Increased staff numbers	21
Use of MHA	17
Availability of other treatment	17
Early follow-up after discharge from inpatient care	15
More beds/facilities	12
Different powers under MHA	12
Higher dose of medication	8
Greater availability of secure facilities	6
Other factors	29

Source: derived from Figure 41 of *Avoidable Deaths 2006*

The original Figure in *Avoidable Deaths* from which this Table is derived appears to be based on 195 cases though this is not stated explicitly. The most frequently mentioned factors were better patient compliance, closer contact with the patient's family, improved staff communication and better staff training. It is noticeable that many of the issues mentioned above also figure in the *Avoidable Deaths* findings: better liaison between different services, use of MHA, and Availability of other treatment. The London Inquiries did not include any apparent calls for more secure accommodation or higher doses of medication. We are not claiming that if the issues raised by our investigation of Inquiry reports had been attended to then the homicides might have been avoided but we are saying that some problems have been identified in a variety of investigations using different samples and different methodologies.

When drawing conclusions on *Findings on the CPA from Homicide Inquiries*, Warner states

> *Many of these inquiries found evidence of incomplete or ineffective implementation of the CPA in some areas, leading to negative outcomes. Recommendations included calls for local practice to be driven by adequate local policies and procedures, based on*

national standards, and the need to ensure comprehensive multidisciplinary assessment, care planning, and review processes take place. Many reports stressed the need for service users and carers to be fully involved in the CPA, and for effective liaison and communication with other services. The importance of including risk assessment and management, signs of relapse, and contingency plans for working with people whose care plans fail and those who are difficult to engage with services, was noted. Some reports emphasised that service users should be placed on the appropriate level of CPA, with safeguards to ensure they are not removed from the CPA by one professional acting without agreement at a multidisciplinary review. Many reports concluded that the CPA should be supported by clear documentation, easily accessible by all agencies involved, with regular local auditing to ensure effective implementation.[8]

These comments could equally well have been made about the London Inquiry cases. But not all commentators on homicide inquiries concentrate so explicitly on CPA issues. Herschel Prins who has chaired nine inquiries argues that nine themes have emerged from inquiries:

1. *There is still a long way to go towards encouraging mental health and criminal justice professionals to take a broad view of an individual's social functioning in relation to their illness. This may arise, in part, because of the tendency for medical practitioners to play a dominant role in the practice of psychiatry. To some extent this is understandable, given that in cases governed by the current mental health legislation the RMO is held responsible in law for acts of negligence or omission.*
2. *The importance of matching past behaviour to resent behaviour has often been overlooked. More needs to be done in encouraging workers to compile careful chronologies of patients' lives.*
3. *Linked to point 2 is the need for maintenance of adequate records and the development of common systems of recording. For the most part, mental health and criminal justice services have their separate systems of record-keeping.*
4. *Too little attention is paid to the importance of vulnerability in the assessment and management of risk; that is, of not placing patients and offenders back into situations which may promote the commission of further disastrous actions, and the completion of what the late Dr Murray Cox called 'unfinished business'.*

[8] Warner, L. (2005) *Review of the Literature on the Care Programme Approach*, London: Sainsbury Centre for Mental Health , p.4

5. *There is a compelling need to develop more sensitivity to issues of race, culture and gender differences. Most racism in institutions, be they opened or closed, operates as at a subliminal level (see Macpherson report 1999).*

6. *Workers need to develop robust approaches to dealing with offenders and offender-patients. Concern for civil liberties has sometimes obscured the need to place public protection at the forefront. A more searching, questioning stance is needed.*

7. *Levels and modes of communication between professionals still leaves a lot to be desired. Top-down approaches to care and management are still too prevalent; sharing of information is still not as good as it might be and some workers are often defensive, taking comfort from the fact that 'knowledge is power'. There is too much of a tendency to hide behind confidentiality as a defence to information sharing, as is the tendency to 'go it alone'.*

8. *Finally, the roles played by, and support for, family and other close carers have not been adequately addressed – sometimes with tragic consequences.*[9]

The issues Prins identified are very similar to those that we have found in the sample of London Inquiries that we have investigated above.

The Healthcare Commission carries out annual surveys of patients using every mental health and social care Trust in England[10]. Each questionnaire contains about 50 questions covering a broad range of topics that give a good indication of the quality of the care provided by each Trust. The broad categories of questions are about the care provided by the various health professionals, information about medication, the availability of counselling, aspects of the care planning, coordination and review, support in the community, crisis care, involvement of the family or carer, and an overall assessment of care received from the mental health services. The information given by respondents to the survey may be skewed in a variety of ways, so it is impossible to tell whether they are describing current service provison for the majority. All of the following discussion is based on nine of the ten London Trusts (results for the Tavistock and Portman Trust are not available). The behaviour of mental health professionals is generally well regarded in response to question about being treated with dignity and respect, being listened to and being given explanations.

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[9] Prins, H. (2004) 'Mental Health Inquiries – "cui bono?"' pp. 25-6 in N. Stacey and J. Manthorpe (eds) *The Age of the Inquiry – learning and blaming in health and social care*, London: Routledge

[10] The findings are available on the Healthcare Commission website.

It is clear from responses that non-medical interventions were not frequently available to those who replied to the 2007 survey. When respondents were asked if they had seen anyone else from mental health services in the last 12 months (question 12) most of those who replied said that they had seen someone else (varied between 53% and 66%). When asked if they had a say in decisions about medication, most had some say in this decision (varied between 73% and 87%). When asked about the side effects of medication, most said they had been given information (varied between 55% and 78%).

When asked about aspects of CPA, the situation changes. Sizeable groups said that they had not been told the identity of their care coordinator, the variation was between 50% and 80% who said they had been told (question 26). When asked if they had been given or offered a written or printed copy of their care plan, the answers ranged between 26% and 65% who answered in the positive. When asked if they had been involved in deciding what was in their care plan between 59% and 81% said that they had (question 30). When asked if they had had a care review in the last 12 months between 51% and 73% said that they had. When asked is they were told they could bring a friend or relative to care review meetings between 68% and 89% said that they had (question 32). When asked if they had received any information about local support groups for mental health service users a significant proportion of respondents said that had not been given this information but would have liked to have it (varied between 46% and 63% of those who received information or would have liked to do so – question 38).

Respondents were asked if they had a number of someone in the local NHS Mental Health Service that they could phone out of office hours and large number said that they did not (varied between 41% and 64% - question 42). Of those who had a number and had used it, the majority got through either immediately or in an hour or less. The percentage who received a reply in ‘a few hours’, ’a day or more’ or ‘couldn’t get through’ varied between 9% and 27% (question 44).

Respondents were asked a wider question about whether a member of the service user’s family or someone else close tot them had enough support from health and social services the replies were still positive but with some large proportions of negative replies (varied between 71% agreeing to ‘Yes, definitely’ or ‘Yes, to some extent’ at one extreme with 55% saying ‘No, they have not had any’ at the other – question 50).

We have produced this corroborative evidence to demonstrate that our analysis of the Inquiry reports has not identified a unique set of issues. The issues identified are to be found in Inquiry reports relating to mental health services provided by each of the London Trusts – the issues are London wide and probably nation-wide. Finally, the issues are not limited to some historic period, there is evidence form the Healthcare Commission surveys that service users have reported similar issues in the last 12 months.

Quality criteria for service commissioning

The underlying logic for suggesting criteria which should be used by commissioners to improve the quality of services is that existing national policies have to be central. Planning on the basis of exceptional cases such as the homicides committed by people who meet the criteria for Health Service Guidance (HSG (94) 27) will lead to a distortion of services. We suggest that the strategy to be followed by commissioners should be to plan for the mainstream, the usual case but to monitor actual provison in such a way as to detect the sorts of deficiencies in services listed at length above.

We cannot say from the analysis we have carried out how typical some of these issues are although we have, wherever possible, used corroborative evidence to suggest that some problems are widespread and continue up to the present. Creating a long list of action points will be self-defeating as staff will inevitably prioritise their activities to those which are achievable or provide a defence if some goes wrong – box ticking will become the ethos.

CHI drew a set of conclusions about stronger Trusts on the basis of 35 clinical governance reviews it carried out between 2001 and 2003. The characteristics shared by trusts performing well in clinical governance reviews were:

- Lower vacancy rates, particularly in psychiatry, or active attempts to resolve vacancy problems; high staff morale; good progress with Improving Working Lives.
- Good progress with developing national service framework/NHS Plan services and the care programme approach.
- Leadership is cohesive, visible and well regarded by staff and partners.
- Strong relationships between clinicians and managers.
- Cohesive structures between different parts of the Trust.
- Strong structures to support clinical governance in directorates and sectors / localities; understanding of relationships between the board and directorates, sectors and services.
- Well developed clinical information systems and progress with performance management.
- Good progress on organisational and operational integration with social care.

- Effective communication system in place.[11]

In addition, we would recommend that commissioning bodies have to understand the demographic structure of their area and to commission services which reflect both the needs and the capacities of the communities in the area. This may sound obvious but it is clear from the Healthcare Commission patient survey reports that many service users would like information about local support groups for mental health service users. Some of the cases in the homicide sample could have benefited from access to such support, in the view of those who carried out the Inquiries. What is not clear is whether or not there is local community capacity to provide this kind of support. Government policy is strongly supportive of third sector involvement and capacity building funds are available.

Commissioners will also have to maximise their opportunities of World Class Commissioning for mental health and in order to prove themselves successful, commissioners will need to demonstrate better outcomes; adding life to years and years of life. The goals set out in *World Class Commissioning: vision*[12] are -

Better health and well-being for all

- People live healthier and longer lives.
- Health inequalities are dramatically reduced.

Better care for all

- Services are evidence based, and of the best quality.
- People have choice and control over the services that they use, so they become more personalised.

Better value for all

- Investment decisions are made in an informed and considered way, ensuring that improvements are delivered within available resources.
- PCTs work with others to optimise effective care.

Within this broad framework commissioners will have to build in social inclusion for groups which currently suffer multiple deprivations in addition to metal illness e.g. homelessness,

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[11] Commission for Healthcare Improvement (undated) *What CHI has found in mental health trusts - sector report*, London: CHI
[12] Department of Health (2007) *World Class Commissioning: vision*, London: Department of Health

substance misuse, and social isolation. The preferred outcome for service users will have to be recovery rather than simpler notions of alleviation of symptoms. Primary and secondary services will have to be much more highly integrated than at present if objectives on the use of the home-based treatments are to be achieved.[13] Partnerships with local authorities and the third sector will be needed to ensure that all services are integrated for the benefit of the service user.

In the grid which concludes the report we have converted the key areas of remediable practice into a series of themes and topics which commissioners would need to pursue to meet both the immediate goals of reducing homicides and other untoward incidents but also to meet the outcomes set by government.

[13] National Audit Office (2007) *Helping people through mental illness: the role of Care Resolution and Home Treatment Teams*, London: TSO. HC 5 session 2007-2008

Provider dimension

It is now essential to turn to providers of mental health services to see how they would have to respond to the demands being made by commissioners. We have tried to place the specifics of our analysis of the forty homicide cases in the wider context of what is known more generally about effective service providing Trusts. In addition to setting out the characteristics of strong Trusts CHI also looked at what those Trusts had done to achieve their objectives. Some, but not all, of these characteristics address the specific key areas of remediable practice listed above. Some have a wider applicability.

Staffing

- Trust strategies to improve staffing problems can include nurse rotation schemes, nursing cadet schemes, flexible working, subsidised accommodation and childcare facilities and outreach work with local communities to promote working opportunities.
- Trust strategies to improve staffing problems can include attracting overseas consultants, increasing number of specialist registrar posts.

Commitment to developing staff

- Ensuring that staff perform their roles effectively through: induction; learning and capacity building; work based assessment and competence; and qualifications linked to job roles and lifelong learning.
- Appraisal and clinical supervision – protection from high workloads and low staffing levels.

Management Information

- Existence and development of performance management information systems to monitor the quality of care.
- Trust-wide information systems access to all staff.
- Staff access to IT systems and knowledge of how to use it.
- Existence of unified service user record system across health and social care teams, accessible out of hours.

Partnership working

- Existence of structural connections to partnership working e.g. jointly funded posts across primary and secondary mental health care. Senior staff with social care responsibilities on executive teams and Trust boards.

- Existence of strong working relationships with local authority departments and third sector organisations.

Safety

Managing risk

- Quality of hospital environments, staffing levels and skills and systems for preventing and managing risk for both staff and service users. Situations include failure to carry out timely investigations into serious untoward incidents, inadequate clinical safety policies and unsafe environments for staff and services users.
- Feedback to staff, dissemination of learning or trend analysis once incident reports have been completed.
- Trust has risk management strategy and structure.
- Consistent approach to prevention and management of violence and aggression. Staff training in management of violence and aggression.
- Safe environment issues include policy and practice around drug administration, line working and the quality of work-place risk assessments.
- Risk registers – corporate and clinical – how these fit into Trust structures including Board level.
- Participation in MAPPA e.g. the appointment of a criminal justice advisor.
- Mechanisms for incident avoidance – opportunity for staff to discuss concerns with senior managers and clinicians – learning from 'near misses'.
- Lone working policies and procedures.
- Child protection – child protection policies and procedures, training in.
- Policies on children visiting service users on adult wards.

Environment

- Modern purpose built accommodation designed to enhance the quality of care, dignity and privacy of services users.
- Violence free areas, appropriate mix of service users.
- Protection of female service users from feeling vulnerable and unsafe.
- Alcohol and illicit drug free environment.
- Activities available to service users through coordinated occupational therapy programmes.

Care Programme Approach

- CPA embedded Trust-wide and service users allocated a care plan and care coordinator.
- Regular reviews of service user's care needs and risk assessment.
- Use a code of practice for managing CPA meetings.

User perspectives

- Policies and procedures for accessing service users' views and using their views on service planning and procedures.
- User involvement in service planning, development and delivery.
- User involvement in staff recruitment and training.
- Trust works with voluntary and user organisations.

Provision of advocacy service

- Trust makes information available on services and rights under MHA in languages spoken in that area.

Provison of culturally appropriate services

- Development of services in partnership with local BME communities.
- Cultural awareness training among staff.
- Catering provision meets dietary requirements of service users.
- Provision of qualified interpreters (i.e. trained in use etc of psychiatric terminology etc).
- Ethnic data monitoring carried out.

Carers

- Provision of support, advice and practical help for carers.

10 High Impact Changes for Mental Health Services[14] is based on work carried out during 2005 and early 2006 by Care Service Improvement Partnership regional development centres which began to identify examples of service and process redesign within local health and social care communities where demonstrable impact is evident and which supports one or more of the high impact change areas.

1 Treat home based care and support as the norm for delivery of mental health services.

[14] Care Service Improvement Partnership (2006) *10 High Impact Changes for Mental Health Services*, London: CISP/NIMHE

2 Improve flow of service users and carers across health and social care by improving access to screening and assessment.
3 Manage variation in service user discharge processes.
4 Manage variation in access to all mental health services.
5 Avoid unnecessary contact for service users and provide necessary contact in the right care setting.
6 Increase the reliability of interventions by designing care based on what is known to work and that service users and carers inform and influence.
7 Apply a systematic approach to enable the recovery of people with long-term conditions.
8 Improve service user flow by removing queues.
9 Optimise service user and carer flow through an integrated care pathway approach.
10 Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce.

These high impact changes can be seen as a means of auditing local service provision. They provide a means of shorthand checklist of tests for the usefulness of provision of mental health services.

Key performance indicators

This is not the place for an extensive review of key performance indicators either individually or as entire systems. What follows here is a brief overview of some of the major considerations which should apply to the development of key performance indicators with specific reference to mental health services.

In 2005 the Australian Government Department of Health and Ageing published Key Performance Indicators for Australian Public Mental Health Services which included an international review of developments in performance indicators for mental health services. The international review covered the United States, the UK, Canada, New Zealand, the European Union and Sweden. The authors concluded their review in the following terms:

- Although development is only at an early stage, most Western countries are working towards comprehensive frameworks for measuring performance of their mental health services. There are differences in emphases and terminology but there is also substantial convergence in the domains targeted for performance measurement.
- Performance reporting systems are generally being directly aligned with strategic policy goals and focused on encouraging action by measuring the things that matter to consumers, service providers, health care organisations and funders.
- Most government sponsored mental health indicator initiatives underway recognise the pragmatic reality that investment at this scale needs to serve a number of purposes and users.
- Most frameworks are designed to aggregate information at the level of national and regional populations and for key population groups, and to be used across a range of organisational structures and service categories to enable context specific performance review.
- Indicators for mental health are generally built from multiple data sources and require a combination of service utilisation, consumer survey and clinician-rated outcomes information.
- Whatever performance framework is adopted, emphasis is being given to ensuring that performance dimensions and their associated indicators need to be easily understood by all the stakeholders and should serve as triggers for action.
- Concerns about the safety of mental health care are being given greater focus, as they are more generally in the health industry. This has significant implications for

performance measurement because few countries collect the type of data needed to build indicators.

- Long lead times are involved in the development work. There is general recognition that there are few quick solutions and that a long term investment is required. (NMHWG Information Strategy Committee Performance Indicator Drafting Group (2005)).

This report begins from the view that the framework allows progress from objectives through outputs to outcomes. It begins with proposition that performance comprises three components – equity, effectiveness and efficiency which are regarded by the Australian Government as primary values for any service of this type. Each of these, in turn, has demonstrable outputs leading to outcomes. The outcomes are 'prevalence of mental disorders', 'mortality due to suicide' and 'quality of life'.

The authors argue that any system of key performance indicators must help answer the questions:

- How well is the health system performing in delivering quality health actions to improve the health of all Australians?
- Is it the same for everyone?

The authors believe that mental health performance has to be seen in terms of nine 'domains' which may in turn need more specific sub-domains which may change over time as services improve and develop. Domains may have clinician as well as consumer perspectives and some indicators may map on to more than one domain. The domains are:

- Effectiveness – care, intervention or action achieves desired outcomes.
- Appropriateness – care/intervention provided is relevant to the client's needs and based on established standards.
- Efficiency – achieving desired results with most cost effective use of resources.
- Accessible – ability of people to obtain health care at the right place and right time irrespective of income, geography and cultural background.
- Responsiveness – service provides respect for persons and is client orientated. It includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider.
- Safety – the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.

- Continuity – ability to provide uninterrupted, coordinated care or service across programmes, practitioners, organisations and levels over time.
- Capability – an individual's or service's capacity to provide a health service based on skills and knowledge.
- Sustainability – system or organisation's capacity to provide infrastructure such as workforce, facilities and equipment and be innovative and respond to emerging needs (research and monitoring).

These domains tend to be process-oriented and are concerned with outputs rather than outcomes. They are also a list of the attributes that service provision should have.

An obvious first question to ask is whether there are performance indicators already in existence which could be used to access performance. Comments about reinventing the wheel spring to mind. The Healthcare Commission has been carrying out annual health checks on mental health trusts for some years and it has a well developed methodology for doing so. The Table below shows the Commission's proposals for the next annual health check. The 19 mental health indicators are grouped in four broad domains – health and wellbeing, clinical quality, safety and patient focus and access. The rationale for the inclusion of each indicator is also presented.

	2008/2009 Mental Health indicator	**Rationale**
Health and wellbeing	Community Mental Health Team (CMHT) integration for older people	The National Service Framework for Older People requires that older people and their carers have access to integrated services provided by the NHS and councils, to ensure effective diagnosis, treatment and support.
	Data quality in ethnic group	Good quality ethnic group data supports service planning and delivery by helping to identify and promote action to reduce health inequalities and monitor the cultural appropriateness of services.
	Social inclusion (e.g., number of people with help finding work)	The care programme approach (CPA) should include action and outcomes about people's social needs to increase the prospects for sustained recovery and health and wellbeing.
	Health promotion for staff – from staff survey	*It is a good indication that public health is a priority if trusts are focusing not just on their local populations but also on their employee population. It means that not only are NHS staff informed about their own health and wellbeing, but that they are better able to act as ambassadors for healthier choices.*
	Physical health assessments (Secondary provider level indicator(s) to be developed)	The CPA should include action and outcomes about the physical health needs of people with mental health problems, who are far more likely to be at risk in this area when compared with the general population.

Clinical quality	Patterns of care from MHDS & HES (e.g. the average length of time people are supported by community services post-discharge, emergency psychiatric readmissions, percentage of people with care coordinator recorded on discharge)	There is no nationally established measure of the outcome of care that is available to directly measure clinical effectiveness in mental health. 'Proxy' measures are needed, on activity and systems, to show that services are implementing policies that support better outcomes of care
	Patterns of care reported in patient survey (e.g. percentage of people who know who their care coordinator is, percentage of people who have had a care review in the past year).	There is no nationally established measure of the outcome of care that is available to directly measure clinical effectiveness in mental health. 'Proxy' measures are needed, on activity and systems, to show that services are implementing policies that support better outcomes of care
	Completeness of the Mental Health Minimum Data Set (MHMDS)	The Mental Health Minimum Data Set (MHMDS) has been mandatory since 2003 and needs to be improved to meet its potential for monitoring, assessing and improving local and national clinical effectiveness.
	Access to Crisis resolution home treatment teams (CRHT) (e.g., proportion of admissions to inpatient services that did not involve the CRHT	To avoid unnecessary use of acute inpatient hospital services and ensure that care takes place in the most appropriate setting, crisis resolution home treatment teams should act as a gatekeeper for people who may require access to inpatient mental health services.
	Child and adolescent mental health services (CAMHS) (Provider level indicator(s) to be developed)	A joint cross-government public service agreement target is currently in consultation that will (in part) include children's health and psychological wellbeing. Effective indicators will be needed at all levels of the health system to support the target implementation.
	Clinical staff receiving role specific training (e.g., CPA, medicines management, suicide risk, carer support, dual diagnosis, psychological therapies).	*Clinical staff should receive sufficient training to support policy implementation. From 2007 onwards the annual staff survey for mental health trusts collects recent training data specifically for mental health trust clinical staff on CPA, medicines management, suicide risk, carer support, dual diagnosis and psychological therapies.*
Safety	Proportion of people receiving follow up contact within seven days of discharge from hospital	Follow up within seven days of discharge from secondary care settings is specifically associated with the prevention of suicide. This reflects the requirements of standard seven (preventing suicide) outlined in the National Service Framework for Mental Health.
	Medication – (e.g., the number of people who were told about possible side-effects of medications) from patient survey	Medication is a major area of risk for patients. In 2006/07, medication errors accounted for 62,660 of the 727,736 patient safety incidents reported to the NPSA's national reporting and learning system. Involving patients in the management of medicines is one way of helping to reduce risks
	Single sex accommodation (provider level indicator to be developed)	Recent national policy and reports have set out recommendations for improving the provision of care in safe, therapeutic environments, that treat people with dignity and respect and ensure sexual safety

Patient focus and access	Delayed transfers of care	Evidence suggests that a significant proportion of non-acute and mental health beds are occupied by patients whose discharge is delayed. Recent changes in mandatory data collections will enable mental health trusts to be assessed on their performance in this area
	Building closer relationships (e.g. respect and dignity, being listened to carefully) – from patient survey	The care programme approach stresses the importance of involving people who use services and their carers in decision making during their assessments and planning of support and care services. Recent reviews and reports have shown that there is high variability and often low performance in this area
	Choice and involvement (e.g. reported involvement in decisions about care and treatment) – from patient survey	
	Cares (e.g. % of people who report that their family and/or carers have received enough information and support) - from patient survey	
	Out of hours access (e.g. number of people who reported having the number of some one to call out of hours) – from patient survey	The *National Service Framework for Mental Health* says that all people need to be able to access services when they need the, particularly when in a crisis, but recent surveys have shown that nationally only around 50% of people have the phone number of someone to call out of hours

(Source: Healthcare Commission (2007) *Developing the annual health check in 2008/2009*

Note: The Healthcare Commission intends using some indicators from the NHS staff survey and these items are in italics.

While there is much in this list to applaud and indeed we will replicate some of the indicators later, there are several reasons why a different set of indicators should be employed:

- The key performance indicators proposed below were generated from the 40 homicide investigation reports covering nine of the Mental Health NHS Trusts in London.
- The timescale may not be appropriate in a commissioning context; information reporting should be more frequent that the annual cycle to which the Healthcare Commission works, greater frequency of audit may be important to a Commissioner with concerns about areas of provision.
- The requirements of a commissioner are not the same as those of a national inspection body which may be more interested in different areas of activity from those being assessed by the Healthcare Commission.
- The level of detail required by a commissioner monitoring specific services are different from that required by a national inspecting body, the existing indicator regime has not prevented a number of serious untoward incidents from occurring.

The key performance indicators listed below derive from observed deficiencies in existing services.

Clearly the need for different and / or more indicators for commissioning purposes is not without costs and not doubt be seen as an extra burden by those required to complete and collate them but if the Healthcare Commission's annual health checks meant that there were no serious untoward incidents then this piece of work would not have been commissioned.

The indicators generated by close study of the 40 homicide investigations cover a wide range of issues and cover various responsibilities. Many of the indicators are quantitative but we also recognise the need for qualitative assessments to be made as it is clear from the investigation reports that while a great deal of activity took place with many of the service users it was often unfocused or ineffective. Treatment plans were frequently drawn up, implemented and persisted with remorselessly even in the face of varying levels of unwillingness to comply. Reviews were rare.

We have commented on the need for clinical and nursing staff to take an investigative approach to the risk factors posed by service users and there is a similar obligation on the part of Trust Boards in respect of how they have to consider information about the workings of their Trust and its services. Large amounts of data are collected, collated and analysed for Trusts in their quarterly key performance indicator reports. Many of those currently being employed are process oriented and link to targets. There is an important for bringing together sets of results which shine a different light on the same area e.g. figures are given for the percentage of complaints resolved within 20 days (which is admirable) but no one knows whether the resolution was satisfactory and how the results have been used to improve service delivery.

Audit - quantitative

One of the recurring comments in the homicide Inquiry reports that we analysed was the statement that new policies were rarely if ever needed; what was required was the routine application of policies that were already in existence. We recommend that time and energy are put into auditing existing practices to discover the extent to which daily activities adhere to Trust policies. We suggest that this is the first step towards improvement of care and treatment.

There should be regular quantitative checks on:

- Records – whether being kept in compliance with Trust record keeping policies.

- Repeat prescriptions, how their use monitored and practice reviewed (evidence of prescription repeated for three years without any face to face with service user – relied on relative to monitor compliance).
- Training programmes for all levels of staff – to ensure that there is a connection between the training plans and issues raised in incident raised in incident reports, Healthcare Commission reports etc.
    - existence of training courses.
    - monitoring of mandatory training.
    - monitoring of attendance by staff including night shift staff.
    - compliance of staff with professional (College) CPD requirements.
    - evaluation of 'fitness for purpose' of training provided.
    - regular programme of training needs analysis.
    - provision of training on Trust policies and procedures for locum and agency staff.
    - personal development programmes.

Staffing issues – data to be collected quarterly

- Staffing levels.
- Monitoring staff working hours.
- Skills mix.
- Use of bank and agency staff.
- Staff retention rates.
- Use of staff exit interviews.
- Recruitment of nurses from BME and other underrepresented groups.
- 24 hour cover of staff with knowledge of child protection issues.
- Existence of named doctor for child protection.

Application of Trust policy on staff appraisal

- Existence of staff appraisal.
- Evidence of application to all staff.

Complaints and the way they are handled should be seen as indicator of health of a Trust.

- Monitoring of number and type.
- Monitoring of complainants by age, gender, status and ethnicity.

Staff and patient safety

- Number and nature of incidents.
- Rate of incidents.
- Staffing levels when violent incidents occur.
- Recording staff movements etc in respect of lone working.
- Record keeping in respect of child protection policies.

Information should be collected routinely to enable diversity monitoring of

- Service users.
- Complainants.

Risk registers should be established and reviewed regularly as part of Trust Board and Audit committee agendas

- Assessment tools for corporate and clinical risk.
- Routine monitoring of high risk areas and activities – including physical environment e.g. ligature points and limited medical cover.
- Participation in MAPPA and / or contact with criminal justice system.

Audit – qualitative

In addition to a regular system of quantitative audit there needs to be a rigorous system for assuring the quality of treatment and care. As mentioned above the principal theme of many of the Inquiry reports concerned the quality of the work being done by all levels of staff. Assessments were based on limited amounts of information from a restricted number of sources and frequently assessments were not completed. On some occasions, the wrong people were making decisions or they were making decisions they did not have the authority to take. Although staff supervision and mentoring existed in theory it was rarely practised. The provision

of clinical and nursing leadership was often compromised by staff shortages, the employment of staff at the wrong levels and poorly drafted contracts of employment.

We recommend that there is a regular system of auditing of the quality of provision and that the results are reported to the Trust Board and the Audit/Clinical Governance Committee structure. These are essential issues for Board level oversight and action as the reputational and other risks are extremely high. These are also some of the key areas in the determination of Foundation Hospital status.

There should be a programme of regular audit of:

- Clinical governance.
- Clinical leadership and supervision.

In addition to the Healthcare Commission annual survey of service users, there should be a programme of:

- User Surveys including specific subsamples to investigate the views of hard to hear subgroups.
- Stakeholder satisfaction survey especially GPs, partner organisations such as social service departments (on child protection issues/safeguarding children), housing, MAPPA.
- Staff – state of staff morale which would help to corroborate the staff appraisal process.

Benchmarking

Benchmarking is a useful way of comparing Trusts' performance against their peers and we recommend that more should be done. At the moment the 32 London Boroughs are clustered into five groups using the Local Index of Need and analyses are presented on admission rates, CMHT caseloads and so on. Data from the Healthcare Commission's annual service user surveys provide an alternative method of benchmarking.

Healthcare Commission benchmark reports are calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. A score of 100 represents the best possible response. (Trusts will have differing profiles of people who use their services. For example, one trust may have more men using their services than another trust. This can potentially affect the results because some people tend to answer questions in a different way than others, depending on their age and

gender. Therefore, the results have been weighted by the age and gender of respondents to ensure that no trust will appear better or worse than another because of its sample profile. The results for each trust are 'standardised' in this way, so that their age-sex type profile reflects the national age-sex type distribution (based on all of the respondents to the survey). This enables results from trusts with different profiles of people who use services to be compared.) Therefore, the higher the score for each question, the better the trust is performing.

A 'scored' questionnaire showing the scores assigned to each question can be downloaded from the website. The scores are not percentages, so a score of 80 does not mean that 80% of people who have used services in the trust have had a particular experience, but that the trust has scored 80 out of 100. It is not appropriate to score all of the questions within the Healthcare Commission's questionnaire, so for benchmarking purposes, only questions which enable a trust's performance to be assessed are scored.

Since the score is based on a sample of people using services in a Trust rather than on everyone, the score may not be exactly the same as if everyone had been surveyed and had responded. Therefore a confidence interval is calculated as a measure of how accurate the score is. A confidence interval is given by an upper and lower limit within which you have a stated level of confidence in which the true mean (average) lies. The width of the confidence interval gives some idea about how uncertain it can be; a very wide interval might indicate that more data should have been collected before any conclusions are made.

Service users were asked 'Have you been given or offered a written or printed copy of your care plan?' and in the London Trusts the percentage answering in the positive varied between 26 and 66%. But if the answers were scored in the way described above then it is possible not only to compare the 'scores' for of the London trusts but also to compare their scores with the score needed to be in the best 20% of trusts and see where each stands in relation to the best scoring Trust in England as in the Table below.

TRUST	**Scores for this NHS Trust**	95% confidence interval		Threshold score for the best 20% of NHS Trusts	Highest score achieved (all Trusts)	Number of respondents
		Lower	Higher			
Camden and Islington	51	44	59	67	81	178
Barnet, Enfield and Haringey	65	59	72			208
Central and North West London	51	44	59			178
East London and the City	54	47	61			201
North East London	66	60	72			220
Oxleas	48	42	55			220
South London and Maudsley	26	19	32			173
South West London and St George's	54	47	62			174
West London	65	57	72			161

One can see from this table that although virtually all London Trusts scored more that 50 on this question, none actually met the threshold for the best 20% of NHS Trusts (67) and all were some distance from the highest score achieved by all NHS Trust in England at 81. These Healthcare Commission Tables give Trusts a series of benchmarks against which they can assess their performance and base their action plans for service improvement without the expense of having to collect additional data.

Service users consultation

We held two meetings with services users. The format for both sessions was informal and was designed to follow leads provided by the service users themselves after an introduction to the issues identified by our analysis of the Inquiry reports. The first meeting was held with representatives from the former SHA boundaries in London at the London Development Centre Service User Consultation Group on 26th March 2008. The second was held at Broadmoor High Security hospital on 2nd April 2008. Much of what follows is in the form of direct quotations. The characteristics of the two groups are very different and for that reason we have presented their comments separately.

The London Development Centre Service User Consultation Group

CPA

It was common to have problems with this and it was felt that staff see this as unnecessary paperwork and don't have a lot of time to do it.

It was reported that one area had carried out a survey of their service users - 45% who should have a CPA care plan knew of it and had only seen a copy; 55% of those who should have had a care plan had not seen it nor had a chance to sign or agree to it (this was a similar pattern they felt in other areas).

One service user shared her personal experience of a care plan being drawn up in 2001 but within six months this was out of date – names and telephone numbers changed but it was never updated despite the service user requesting this – service user stated that, "when I get ill I get confused, I need this information to know who to contact".

Concern was expressed that the free concessionary travel was being inconsistently applied across London (it may be true that in certain areas advanced CPA gives access to free travel on public transport there was suggestion that some people were being graded 'down' to Standard CPA to avoid eligibility).

It was reported as being very rare to go to a meeting and get a care plan promptly in that it could take three to six months, by which time you are due your next one.

There was a general feeling that a great deal of work around the CPA is about rationing the services.

The view was also that if a service user is only seeing a Psychiatrist (and no one else on the team) then they would not be on CPA -

> *"If I could change one thing it would be to stop the practice of service users being reviewed by junior doctors every 3 – 6 months. These people change all the time and people have to keep starting from scratch telling their stories. This is discouraging and disturbing for people having to repeat their story and going back to the beginning. We need a liaison worker who can inform people what is available locally these rotational junior doctors know nothing of the local services".*

We believe this person was describing the role of the Care co-ordinator.

> *"My wife (also a service user) had no paperwork at all; she just received a depot injection every two weeks. I often asked but there was never a named person that I could contact."*

> *"For myself I have been involved with services for 33 years and got my first care plan last July. Before that I was never told about a care plan but was required to have a new risk assessment every time I wanted to re-access the day care centre – I never knew what happened to these."*

> *"People still don't have a great awareness of CPA but it is getting better. However, the staff don't take any notice of what is written in the CPA and in any case there is such a large turnover of staff you rarely see the same person."*

It was also reported that lot of staff thought that it was not wise to tell a seriously ill person what was in their CPA.

> *"I discovered that information about me was held in three different files – some electronic and some paper systems. I found that electronic systems were more difficult for staff to delve into as they didn't know the computer systems well enough to know where the information was stored".*

GPs

In the past many people liked to keep separate secondary care and primary care.

"There is hardly any information between GPs and secondary mental health care"; it is hard to change GPs' attitudes; some service users feel that their GP may discriminate against them if they knew the full extent of their mental health problems.

> *"Over a period of time I found that all the letters to my GP went to the wrong surgery."*

> *"Sometimes my GP refuses to prescribe the drugs that my consultant says I should have."*

Most service users get their medications from the GP as repeat prescriptions and see no one from either primary or secondary services – they only re-engage if something happens.

Medication

> *"Whether you take the medication you are prescribed depends on the relationship that you have with the person prescribing it. If it is changing all the time then you won't trust the person the same."*

> *"It is not a genuine equal dialogue about medication; prescribers don't accept or understand the problems that the medication gives us".*

> *"Still talk about 'compliance' – the whole language is wrong".*

> *"Most people lie about medication (whether they are taking what they should be) and most people have had bad experiences with medication from one time or another."*

> *"Needs to be better training for prescribers – needs to be a more honest discussion then perhaps patients would be more honest."*

> *"Some patients are threatened with being admitted to hospital under section (of the Mental Health Act) if they do not take their medication."*

> *"The 'yellow card' scheme is available for patients to report problems with drugs but this is not promoted in psychiatry – there is an expectation that we should just put up with any side effects."*

Discharge in Absentia

> *"This is a common experience (happens all the time). When you are ill you often forget about appointments (should be like a dentists and be called the day before to remind you). I once had trouble with another patient in a therapy group who attacked me (twice) I didn't go to the next meeting and they discharged me."*

GP appointments not being attended with no follow up when this happened was a commonly reported problem.

Risk

"Staff loose sensitivity about language. It is very upsetting for service users to be told they are being risk assessed – it should be stressed that this is routine and is nothing peculiar to them."

"Advanced decisions could be a good way forward and more regular use of crisis cards."

Other issues

There is a hospital leavers' group in one Borough which has proved to be very useful with the same area also having a user-led crisis house where people can self-refer which is usually a rarity. People will sometimes not present to services because of fear (of being sectioned or incarcerated) and will hide away when they need help most.

People could have information on whom to contact; who not to contact; what has helped in the past; what treatments they do not want to have.

"Voluntary sector can play a bigger part; they are more trusted and more empathetic with service users."

Internet help is becoming increasingly useful (user to user).

"The services keep messing about with catchment areas – they take on a new consultant and/or care co-ordinator, carve out a new patch for them and everyone in that area is transferred to them – no choice or say about the matter. There is no appreciation of the importance of consistency for the service user – continuity is really important."

Homeless people are often re-housed miles away from their home area and any support systems that they may have become lost

Broadmoor Hospital

On 2 April 2008 we attended Broadmoor Hospital to meet a group of patients. It is likely that two of the patients were from our sample of 40 patients. We were greatly helped by the Responsible Medical Officers who identified the group of patients for us to see. The response to our timescale demands by the doctors and staff was swift and welcoming.

The patients consisted of a group of younger (male) patients who represented themselves well and clearly.

As with the group of service users consulted from within the wider community of London we asked the Broadmoor patients the same range of questions. The Broadmoor patients' responses were different.

The majority had used drugs, mainly cocaine and cannabis. One patient had considerable knowledge of life on the streets of the capital and gave an excellent and vivid account of his experiences. He had used GPs support attached to homeless persons units but left when enquiries were made about his psychiatric history because of his paranoid ideation. The majority had wished that they should have been detained for longer periods of time when they were not engaging with services and were as they saw it out of control of themselves. The use of cocaine really worked for one particular patient, in that it made him feel great – the problem was it only lasted a short time, but helped dull his experience of life on the streets.

As a contrast one patient said that he had a good relationship with a community psychiatric nurse and his GP, although he too wished he had been stopped from his disengagement from services as he was steadily becoming unwell and stated that cannabis was his downfall and when 'outside' he never used medication, taking it for a short time and then stopping. There was a feeling that professionals never believed patients about the side-effects of medication and they preferred to be ill rather than have these unpleasant feelings. Some saved medication in the hope if they took more in one go it would help alleviate their symptoms.

CPA reviews were an event many did not recall. It was felt that services should intervene 'stronger' at an earlier stage to prevent a person without insight from drifting into severe difficulties. There are instances in the review exercise of the various investigation reports that highlight the poor application of CPA – especially in pre discharge Section 117 planning for previously detained patients. What all patients identified was there lack of understanding or knowledge of the term care co-ordinator.

The paucity of the positive aspects of life experience was apparent in this group. There was a general feeling that they had struggled for long periods of time alone and relatively unsupported. There was comment and discussion on what the word 'Assertive' in Assertive Outreach Team should mean.

Patients had a poor recall of family members being involved in being helped in developing their understanding of the planning process of their care, although in some cases parents were in different parts of the country. One comment was that if parents knew what had happened they could not cope; but they needed to hear these things as painful as they could be. There was for some of this group the hope of reconciliation with parents. One patient stated that a lot of his family would not speak to him because of what he had done, but his mother travelled regularly a great distance to see him.

Many of the patients had used voluntary services, particularly those providing shelter type accommodation and resulting networks and have positive words to say how helpful they were at times of great need. Homeless people fall outside the norms of society – no home, no job, no GP, no address for correspondence etc. There was general consensus that voluntary organisations asked less questions and were less threatening and when in the wider community more helpful.

All patients agreed that more should be done to pursue them if they missed appointments they knew they had to attend but could not make by simply not having bus fare, were paranoid, suspicious and angry.

The appointment of a care co-ordinator was not recognised as a supportive opportunity available to them. All patients stated that they now, since their detention in Broadmoor Hospital have received six monthly reviews and were clear about their care plan. They were positive about this experience. Should this process have been consistently achieved in wider mental health services their situation may have been different.