HASCAS
Health and Social Care Advisory Service

Independent Investigation Progress Report

into the

Care and Treatment Provided to Ms A

by the Dorset HealthCare University NHS Foundation Trust

Commissioned by NHS England

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1. Background to the Audit

1.1. In 2011 an Independent Investigation into the care and treatment of Ms A was commissioned from HASCAS jointly by NHS South West and Bournemouth and Poole Adult Safeguarding Board. The Investigation was pursuant to HSG (94) 27 and the Bournemouth and Poole Adult Safeguarding Serious Case Review Policy and Procedure. This Investigation was asked to examine the care and treatment received by Ms A in the years and months prior to the killing her mother, Ms B, on 25 of August 2010. The report was published on 14 January 2014.

1.2. In May 2014 NHS England Southern Region commissioned HASCAS to undertake a separate HSG (94) 27 investigation pertaining to another homicide involving three service users who had received their care and treatment from the Dorset HealthCare University NHS Foundation Trust. This was the Ms Y Investigation. In addition to this work HASCAS was also asked to review and test the Trust and Clinical Commissioning Group's governance, assurance, oversight and sign off of the Ms A action plan measured against the new NHS England serious untoward incident framework and best practice. The Framework states;

> *"It is important to recognise that the closure of an incident marks only the completion of the investigation process. The delivery and implementation of action and improvement may be in its infancy at this stage. Implementing change and improvement can take time, particularly where this relates to behavioural and cultural change. It is not unreasonable for improvements to take many months or even years in some cases. It is important that providers and commissioners invest time and resources into monitoring and progressing with long term actions, particularly where*

these address the causes contributing to other incidents across the system. A mechanism for the monitoring and review of actions should be agreed by the provider and commissioner".

2. Inital Findings and Conclusions of the Independent Homicide Investigation

2.1. The Ms A Independent Investigation made the following findings:

Diagnosis

2.2. From 2000 to 2007 Ms A's primary diagnosis was Paranoid Schizophrenia. In 2007 while she was treated in Nightingale House the Rehabilitation Consultant Psychiatrist (Consultant 5) altered her diagnosis to Schizoaffective Disorder. The change in diagnosis followed a relapse of her illness when Consultant Psychiatrist 5 observed a number of symptoms and signs that were consistent with this diagnosis.

2.3. On discharge to the Community Mental Health Team in July 2008 the working diagnosis of the Associate Specialist and the Care Coordinators working with Ms A reverted to Paranoid Schizophrenia. They stated they were not aware Ms A's diagnosis had been changed to Schizoaffective Disorder whilst in the Rehabilitation Service. However the Community Consultant Psychiatrist (her Responsible Clinician and Consultant 4) stated his differential diagnosis had always been Schizoaffective Disorder. The Independent Investigation Team found no specific issues in relation to Ms A's diagnostic formulation.

Medication and Treatment

2.4. The Independent Investigation Team found that the medication Ms A was prescribed was appropriate for her diagnoses and within recommended therapeutic ranges. The Investigation Team understood Ms A was always reluctant to take medication, and frequently wanted to either cease or reduce her dosage and she experienced significant extrapyramidal side effects from her antipsychotic medication. The treating teams tried hard over time to establish a medication regimen that would keep her well and also minimise the side effects she experienced. They worked collaboratively with Ms A to try and establish her optimal level of medication. However the investigation did not find evidence of intervention which explored and worked on her attitudes and understanding of the importance of adhering to her medication plans.

2.5. Ms A had a number of episodes of psychological therapy and she appeared to find these periods of treatment helpful. Whilst with the Rehabilitation Service the psychological elements of Ms A's treatment were based on developing her insight into her illness, developing her coping mechanisms and working with her to develop a relapse management plan. When Ms A returned to live in the community she had a period of receiving weekly sessions with a Counselling Psychologist for several months. This gave her the chance to explore her feelings about her illness and its impact upon her life.

2.6. The Independent Investigation Team found that psychological treatment helped develop Ms A's insight into her illness and understanding of her relapse signature. There was no evidence of structured, formal family interventions as recommended

within NICE guidelines. This Investigation concluded this was an important gap in her treatment.

- ***Service Issue One. Ms A's continued non-compliance with medication was a significant part of her risk presentation. The failure to develop an explicit medicine's management plan was poor practice. The treating teams appear not to have understood compliance and non-adherence issues and this is a significant point of learning for the Trust when engaging service users such as Ms A in the future.***

- ***Contributory Factor One. The absence of structured involvement of family and the failure to engage the family in either education or therapeutic interventions as recommended by NICE guidelines was a serious omission. This omission ensured that identified family dynamic issues were not addressed and that Ms A's parents did not understand her in the context of her mental illness. This contributed to the less than optimal management of Ms A's care and treatment.***

Mental Health Act (1983 and 2007)

2.7. The Independent Investigation Team found that the Mental Health Act in its broadest terms was used in an appropriate manner and at the right times in Ms A's care. This Investigation found no evidence that the formal legal and administrative requirements of the Mental Health Act were not completed to the standards required by the law or Mental Health Act Code of Practice. However we found that in a number of areas the clinical practices involved in supporting Ms A when she was subject to the Act were not as robust as they should or could have been.

Section 136

2.8. Section 136 was used in 2005 to bring Ms A into hospital after she was found swimming in the sea naked, and behaving in a bizarre way on Boscombe beach. She was subsequently admitted informally. One month later she left the ward and did not return. She was found by the Police several days' later living on Weymouth Beach. She was not thought by the Police to meet the criteria for Section 136. Eventually staff went from the ward and convinced her to come back informally. This Investigation concluded that in this situation it would have been clinically safer and more legally sound to have sent a doctor and social worker out, who could have assessed her for emergency admission under the Mental Health Act if required.

Section 117

2.9. It was found that three Section 117 meetings were held throughout the 10 years Ms A was cared for by the Trust. The first was in 2006 when being discharged, the other two both occurred in Nightingale Court in 2007 and 2008. It would appear that the first Section 117 discharge meeting met the minimum standards for an effective discharge meeting in that the Consultant and Care Coordinator were present; however the absence of the involvement of Ms A or her family was not good practice. The second and third meetings involved more people and demonstrated evidence of careful and thoughtful multiagency planning. Again the absence of direct input from Ms A or her family was not in line with either local or national policy expectation at that time.

2.10. This Investigation concluded that the service should have called a Section 117 discharge planning meeting when Ms A's discharge from Leven House was being planned in November 2009. That this did not happen was on omission on the part of the Trust and its staff, while the Investigation Team viewed this as predominantly a service issue, they took the view that it was symptomatic of the generally poor coordination and planning of care that is identified in other sections relating to this period of time in Ms A's care.

Section 17

2.11. Section 17 was used twice to facilitate discharge from hospital. The Independent Investigation Team considered that in the first instance in 2006 Section 17 leave could have been used for longer to maintain a more robust legal hold on Ms A in the early stages of her discharge from what had been a very long admission, and her first detention on Section 3 of the Mental Health Act following an episode of assaultive behaviour.

2.12. In the second instance this Investigation concluded it was appropriate to use Section 17 leave prior to conversion to Section 17a Supervised Community Treatment Order.

Section 17a

2.13. Ms A met the criteria for Supervised Community Treatment and therefore use of the Community Treatment Order was appropriate. However members of the treating team did not make the link between this and the expected need to respond accordingly in the event of signs of relapse. This failure meant that Ms A being on a Community Treatment Order did not provide the safety net that it was intended to. Had clinicians responded in accordance with expected practice when Ms A's mental state was first reported as deteriorating, she would have been reviewed within 24 hours of concerns being expressed about her mental state. It is probable that she would have been recalled to hospital. That this did not happen was a serious omission, which will be considered as part of the overall management of care.

Care Programme Approach (CPA)

2.14. The Care Programme Approach did not assume the central position that both national guidance and Trust policy expected of it in the care and treatment of Ms A. This meant that clinical assessment (including risk assessment), care planning and decision making often occurred in isolation one from the other. The Care Programme Approach documentation appears to have been subject to the 'Boiling Frog' [sic] syndrome. The premise is that if a frog is placed in boiling water, it will jump out, but if it is placed in cold water that is slowly heated, it will not perceive the danger and will be cooked to death. The story is often used as a metaphor for the inability of people to react to significant changes that either occur gradually or have not been taken into account fully over time. In the case of Ms A both her Care Programme Approach and risk assessment documentation remained largely unaltered over a nine-year period. It is a fact that changes to either Ms A's presentation or circumstances largely failed to alter the content of the CPA documentation between 2001 and 2010. Whilst it can be said that Ms A's risk factors and relapse indicators changed little over time the Independent Investigation Team made two observations.

2.15. **First:** whilst Ms A's underlying presentation and problems remained the same over a nine-year period her circumstances did not. She transitioned between both

health and social care facilities several times and both risk and clinical assessment and subsequent care planning should have been undertaken at these pivotal points on her care pathway in order to reflect her changing needs. This did not happen in either a timely or coordinated manner. Issues were often identified but it was not possible to see demonstrated a systematic and coordinated response. Instead documentation appears to have been subject to a 'cut and paste' approach which relegated the function of CPA to that of a basic commentary rather than being the cornerstone of care and treatment.

2.16. **Second:** it is a fact that Ms A's underlying problems remained unchanged over a long period of time. This is well documented. A consistent feature is Ms A's relapse indicators, her risk factors and her very low deterioration threshold. Every assessment made over a nine-year period alludes to the fact that Ms A, when well, presented with no risk (or low risk), but when unwell could be a significant risk to herself, to others and from others. It was also recognised that once she was in the community these risk factors would increase and that she would need a consistent level of monitoring and supervision. The Community Treatment Order was put into place in January 2009 for this very reason. The behaviour of Ms A was both known and predictable. This then makes it less acceptable that a more robust crisis and contingency plan was not developed as part of the Care Programme Approach process which was widely communicated to all members of the care and treatment team. Due to the fact that so much was known about Ms A it is of particular concern that no plan was in place to guide the actions of health and housing workers between 23 and 25 August 2010.

2.17. The Independent Investigation Team concluded that the Care Programme Approach was not delivered in accordance with Trust policy and procedure expectation. Communication and care coordination levels were of a poor general standard and assessment and care planning did not take place based upon either Mr. A's presentation or circumstances.

2.18. The absence of effective Care Programme Approach processes was contributory to the poor levels of clinical management Ms A received in August 2010. The days and hours before Ms B died provided a clear window into the observation that the family, the housing support staff and the clinical team, had not established a common understanding of Ms A's needs and risks, or a coherent plan of how deal with her in relapse. In addition it demonstrated to the Independent Investigation Team that those involved in Ms A's care and treatment had not established a level of professional relationship that enabled them to work together effectively as a single multiagency team looking after Ms A's best interests.

- ***Contributory Factor Two. The Care Programme Approach is a mechanism that should ensure the coordination of care for mental health services users with severe and enduring mental illness. In the case of Ms A lip service only was paid to the Care Programme Approach and when she relapsed the safety net of care that should have been provided failed to operate. This made a direct contribution to the multiagency lack of understanding regarding Ms A's crisis plan in August 2010. It also contributed to the delays which ensued in ensuring Ms A's mental state was assessed and managed in an appropriate and timely manner.***

- ***Service Issue Two. The Trust Care Programme Approach Policy was not implemented appropriately in the case of Ms A over a seven-year period. This is evidenced by Ms A's extant clinical documentation and from clinical witness interviews. This lack of implementation is problematic and represents a significant point of learning for the Trust.***

Risk Assessment and Management

2.19. The risk assessment and risk management processes that Ms A was subject to were not in keeping with either local or national policy expectation. Assessment was rudimentary and few attempts were made to develop a formulation which would have ensured Ms A continued to be managed in a robust manner.

2.20. The Consultant Psychiatrist who was Ms A's Responsible Clinician at the time she killed her mother had a sound understanding of Ms A's psychiatric condition and of her latent risk. On the basis of this knowledge he placed Ms A on a Community Treatment Order. The expectation was that any deterioration of her mental state would be monitored and an instant recall into hospital would be made if her mental health relapsed. This plan was not, however, implemented.

2.21. Unfortunately the culture of risk assessment and risk management was weak. Risk assessments appeared to be 'tick box' processes which did not always engage actively with either Ms A's current presentation or social circumstances. The risk assessment process was neither multidisciplinary nor multiagency. Communication between the disparate members of the care and treating team appeared to be weak. The main problem was that Ms A did not have a comprehensive crisis and contingency plan in place which was known and understood by everyone working with her. Despite all of the care and treatment activity that was taking place around Ms A when her mental health deteriorated it was evident that the safety net put in place around her was largely illusory and when tested failed to operate in a timely manner. This was to the ultimate detriment of Ms A's health safety and wellbeing and that of her mother.

- ***Contributory Factor Three: Clinical Risk Assessment and Management practices were uni-disciplinary, poorly documented, and poorly shared between agencies. The consequence of this was that not all involved in caring for Ms A understood what her latent risks were and what to do if they became manifest. This contributed to the poor management of her deteriorating mental health leading up to the death of her mother.***

Safeguarding of Vulnerable Adults

2.22. This Investigation found that vulnerable adult safeguarding procedures were not used in the care and treatment of Ms A. However this Investigation identified that for a significant proportion of the time Ms A was under the care of the Trust she met the criteria, set out in the local Adult Safeguarding policy, to be regarded as a vulnerable adult.

2.23. On occasions she was inadequately protected from harm. This was particularly manifest on the 23 August 2010. At this time Ms A was displaying symptoms of a relapse in her serious mental illness and fluctuating levels of capacity. However despite this Ms A was unable to access the mental health services that should have been available to her. In the context of the safeguarding policy this constitutes neglect.

2.24. Several other concerns regarding other vulnerable adults were identified. Firstly Ms A's boyfriend had been identified as someone who might be regarded as a vulnerable adult. He was a service user, who had become dependent on Ms A. Ms A reported thoughts about stabbing her boyfriend in his sleep. The presence of these intrusive thoughts was taken seriously by the clinical team caring for Ms A and her Consultant Psychiatrist indicated that she should be on a low threshold for recall to hospital. However no safeguarding referral was made or formal plan put in place on behalf of her boyfriend.

2.25. Ms A parents, especially her mother, have been identified by this review as potentially vulnerable adults in their role as carers. However many of the normal safeguards that should have been in place such as carers' assessments, which would have reduced their overall vulnerability to emotional or physical harm, were not put in place.

2.26. Finally: at the time Ms A was reported to be becoming unwell, her level of vulnerability had increased in that she clearly met the definition of a vulnerable adult. This Investigation concluded that not sending out someone to assess Ms A for 36 hours constituted neglect as defined in the local safeguarding policy, as services did not provide the required health and social care services to meet her needs at that time, given her known risks and vulnerabilities and the concerns raised by the Housing Support Worker. This Investigation speculated that it may have been beneficial for the Housing Support Worker or her superiors to have raised a safeguarding concern as soon as they had concerns that the Trust's duty team or crisis team were not going to provide Ms A with the healthcare services they thought she required to keep her safe.

Referral, Admission and Discharge Planning

2.27. Ms A had a relatively large number of admissions, transfers and discharges in the years under consideration. When Ms A moved around the country practitioners across the different Trusts worked hard to keep each other informed of her whereabouts, and ensured that local services picked her up. This was good practice and in keeping with the Care Programme Approach policy requirements.

2.28. The Independent Investigation Team found that Ms A's assessments for admission to hospital typically occurred in a timely manner and were in keeping with the urgent referral criteria set out in the Trust's CMHT operational policies. This Investigation also found that practitioners were willing to give Ms A the benefit of the doubt, and did not admit her immediately if she promised she would take her medication. However even with quite close monitoring Ms A would often not keep to her promises to take medication and would relapse further. On occasions this led to her presenting a risk to herself and others. The Independent Investigation Team acknowledges that this presented a challenge to the clinicians as they had to take into consideration Ms A's preferences, ensure that she was treated in the least restrictive environment, and uphold her rights to liberty.

2.29. Finally the Independent Investigation Team found that appropriate decisions were made about the level of care and support required to meet Ms A's needs. However there is no evidence in the clinical records available to the Independent Investigation that these decisions were based on the comprehensive assessment of needs and risk required by the Care Programme Approach. Both national guidance

and local policy indicated that it is good practice to hold a CPA review at key transition points. Failing to do this consistently in Ms A's case meant that her risks were not comprehensively assessed, and her family and carers from other agencies were not fully apprised or engaged in supporting Ms A to effectively maintain her mental health.

Service User Involvement in Care Planning and Treatment

2.30. This Investigation concluded that whilst there was evidence of Ms A's day-to-day involvement in decisions, this was often reactive rather than proactive. When Ms A was well staff would respond to her wishes and aspirations and supported her as she pursued her interests. When she was unwell staff reacted to Ms A's behaviour and level of illness.

2.31. Ms A appeared to be more proactively engaged with her team in planning her care than may have been the case. The teams working with her appeared to mistake reacting to her behaviours as service user involvement. However this was not service user involvement and engagement in which the service user and the professional staff were in open and transparent dialogue about how to best work together to meet the service user's needs.

2.32. This conclusion is evidenced by the lack of involvement and sharing of CPA care plan documentation. The CPA care plans should have been used as a vehicle to encourage conversations about care and treatment, and help shape changes in the care plans to meet the service user's needs in a more acceptable as well as more effective way. That these documents were not used in this way demonstrated a lack of proactive service user involvement. A more proactive approach to service user involvement in care planning, may or may not have made a difference to the outcomes of Ms A's treatment and care. However it is a learning point for the Trust that service user involvement in decision about treatment and care requires more than reacting to the circumstance the service user presents with. It requires the active engagement of a service user in proactively considering the plans of care and treatment being put in place for them.

Carer Assessment and Involvement

2.33. The joint agency investigation concluded that Ms A's family, although involved in supporting Ms A throughout her illness, had very little proactive interaction with the professionals involved in Ms A's care.

2.34. There was no evidence that Ms A's parents were involved in assessing their daughter's needs or developing her care plans as the Best Practice guidance recommends. Care plans and clinicians' views of risks were not regularly shared with the family, nor did clinicians spend adequate time understanding Ms A's parents' views of her illness.

2.35. The family were not provided with the education or support recommended within NICE guidelines, although on one occasion Ms A's mother was offered a family intervention. There was no evidence, however, that this was followed through. Ms B may have also benefited from a carer's assessment as she was carrying a great deal of responsibility as the named nearest relative.

- ***Contributory Factor Four. There was a failure to effectively involve the family in the Care Programme Approach. There was also a failure to***

provide them with education about Ms A's illness, risk presentation, relapse indicators and crisis plan. As a consequence Ms B did not have the awareness, knowledge or understanding to effectively and safely respond when her daughter started to relapse.

Housing

2.36. The Independent Investigation Team saw evidence that the Trust and Local Authority tried hard to meet Ms A's needs, preferences and safeguarding issues when trying to identify suitable accommodation for Ms A. The level of care taken in this area, and the careful steps taken to move Ms A through to increasing levels of independence was good practice.

2.37. However when Ms A was discharged to Leven House, the team could have taken more time to explore the alternatives to discharging her to a flat with a two-year tenancy and housing support provided via Supporting People funding. This may have been assisted by a multiagency review to ensure that a longer-term tenancy and viable support programme could be put in place prior to her next move.

2.38. Ms A's own statements to this Investigation made it clear that the pressure to move on from her flat within a two-year period was causing her concern. It cannot be known how this concern impacted upon her mental health. Finding long-term tenancies for people who are eligible for Section 117 aftercare is a service issue the Trust and Local Authority partners should seek to remedy.

- ***Service Issue Two. The lack of availability of long term supported tenancies can cause a degree of uncertainty for vulnerable people. This 'move on' culture is not always in the interests of their health, safety and wellbeing.***

Documentation and Professional Communication

2.39. The most significant issue identified within this report regarding multiagency and professional communication was the absence of a recognisable Care Programme Approach process. This severely impacted effective multiagency communication.

2.40. This Investigation found that there was an absence of information-sharing protocols between the various third sector organisations involved in Ms A's care. As a result the third sector organisations were unclear as to what information they could reasonably expect to be shared with them.

2.41. The Independent Investigation Team noted that there was an absence of a regularly updated case summary, or a reliable record of key information, which people could use to orientate themselves to the case in an urgent or crisis situation. It was concluded that the absence of this information was not helpful to the duty team who tried to make decisions about how to manage Ms A's case when they were contacted by the Housing Support Worker on 23 August 2010.

- ***Service Issue Three. There was an absence of information-sharing protocols between third sector organisations and the Trust. This prevented 'joined up' working both in ongoing care, and crisis situations.***

Policy Adherence

2.42. This Investigation concluded that a number of key and interrelated policies and guidance documents were not well complied with. This was because of the way in which CPA and the care coordinator role operated in the Southbourne Community Mental Health Team. It appeared there was a strong Outpatient-based model of care and treatment, which was inconsistent with managing care through the Care Programme Approach. It was also clear that the role of the Care Coordinator had not been fully developed in line with the 2008 guidance in relation to Carer and Family Involvement and coordination of multiagency input into care planning and risk assessment.

2.43. Local policy lacked clear and concise direction on the minimum expectations of care coordination, care planning and risk management. It was also noted that care coordinators were not regularly updated on the core skills they required to fulfil the requirements of the Trust's policies.

2.44. Other elements of national policy and guidance were not complied with because of resource availability or unintended consequences of decisions to restrict access to service. The former meant family interventions were not available, and the latter meant Ms A did not get access to mental health services 24 hours a day, seven days a week when she required them.

- ***Service Issue Four. Poor policy and procedure adherence was in evidence which impacted upon the quality of the care and treatment delivered to Ms A.***

Overall Management of the Case

2.45. Ms A was in receipt of a comprehensive programme of care and support which was assisting her to move forward in terms of independent living and a fulfilled and meaningful life. However underpinning this should have been a robust safety net of care and treatment coordinated using the Care Programme Approach. This Investigation found this safety net was compromised which led to some significant gaps. The key weakness in the underpinning safety net of care was in the poor application of the Care Programme Approach. There was not an effective multi-agency/disciplinary approach to planning and reviewing care. Ms A's care and treatment was delivered by mental health professionals and agencies working predominantly in isolation. This lack of care coordination, sharing of information and joint working, played a contributory role in the service's failure to respond to Ms A in a timely way. This was because people outside and within the team did not have a shared plan or knowledge of what to do if Ms A's mental health started to deteriorate. It may be further speculated that this also meant that the sort of trusting relationships between individuals working for different agencies which facilitate good care giving were also absent.

2.46. While the underpinning safety net of care was weakened by the absence of an effective Care Programme Approach, the failure of the protective barriers put in place to respond quickly and effectively to relapse, were most pertinent to Ms A not getting timely care when she relapsed. This Investigation saw that in principle there were a set of mechanisms in place to intervene in the event of relapse. However in the event of the relapse in August 2010 none of them worked. The duty team did not recognise that Ms A was relapsing from the information provided. The Care

Coordinator when she was consulted did not alert the team to Ms A's risks. This meant she was not prioritised for assessment. The Responsible Clinician had not produced an operational plan which told staff what to do if Ms A relapsed. Therefore the Community Treatment Order did not flag the need to involve the Responsible Clinician and initiate an emergency assessment. The duty team did not make use of the Crisis and Home Treatment Team. These were serious omissions in her care and treatment

2.47. This Investigation found that the decision not to instruct an assessment within 36 hours had a causal relationship to the failure to intervene in Ms A's deteriorating mental health and the consequent attack on her mother on 25 August The case for causality is set out below.

2.48. **Knowledge.** The CMHT Team Leader knew Ms A was on a CTO and understood that this meant she had particular risks if she relapsed. While it was not predictable that she would kill her mother or anyone else, it was known she could be a risk to herself and others when she relapsed. There was information both available and documented about her relapse signature. The information given to the CMHT Duty Worker was a close enough match to Ms A's relapse signature to have identified that her mental health was deteriorating. As a senior and experienced mental health practitioner, responsible for the management of a Community Mental Health Team and the supervision of other practitioners the CMHT Team Leader should have known that his first duty with a relapsing CTO client was to consult with the patient's Responsible Clinician.

2.49. **Opportunity.** 36 hours elapsed between the CMHT duty team being informed of Ms A's deteriorating mental health and the death of Ms B. The Trust's own policy on emergency assessments is to see a patient within four hours of referral. Even if the team had been busy at the time of referral, there was ample opportunity within the 36 hours to have instructed an assessment and intervention.

2.50. **Means.** The Community Treatment Order provided the means to intervene rapidly and have Ms A recalled to hospital. There should have been access to the Crisis and Home Treatment Team if required. These means were available to effect rapid assessment and support for Ms A but they were not utilised.

2.51. Consequently the Independent Investigation Team concluded that whilst the killing of Ms B could not have been predicted, a serious untoward incident of some kind was foreseeable based upon Ms A's previous behaviour when experiencing a psychotic episode. It was the conclusion of this Investigation that the killing of Ms B was preventable and that had a rapid response (as indicated to be required in her clinical record) for Ms A been forthcoming then this tragic incident would probably not have occurred.

- ***Contributory Factor Five. The absence of an effective CPA care planning and coordination process ensured multiagency and disciplinary communication and relationship building was managed poorly. This laid the foundations for people not knowing what to do, or not getting an effective response, when Ms A was reported as being in crises. This made a direct contribution to the failure to manage Ms A in an effective and timely manner between 23 and 25 August 2010.***

- ***Contributory Factor Six. The practice of not asking the Crisis and Home Treatment Team to assess clients in crisis before the CMHT team had seen them contributed significantly to the decision not to provide additional support or assess Ms A within 24 hours.***

- ***Contributory Factor Seven. The absence of clear operational plans regarding the use of the CTO in the event of Ms A's relapse contributed to the failure to discuss the case with the Responsible Clinician; this prevented his timely involvement and ability to intervene.***

- ***Causal Factor One. Not providing an assessment and suitable intervention within 24 hours ensured Ms A's mental health continued to deteriorate, thereby ensuring that she became an increased risk to herself and others. Based upon what was known, and should have been known about Ms A, a rapid response was indicated. The failure to provide the assessment and intervention that she required led to her mental health deteriorating and her risks remaining unmanaged. Consequently Ms A's mental health continued to deteriorate to the point where she killed her mother.***

Clinical Governance and Performance

2.52. The Trust described a robust system of clinical governance, which appeared to be compliant with national standards. However to be effective clinical governance systems need to provide what is referred to in the National Audit Office report on NHS Governance – Taking it on Trust as the second line of defence. This second line of defence provides systems for detecting and closing gaps in service delivery that practitioners and local service managers (the first line of defence) have missed. Evidence from our investigation found that the clinical governance system extant at that time may not have provided an adequate or robust second line of defence. The Trust did not appear to be aware that:

- supervision arrangements for practitioners were patchy and informal;
- audits and quality assurance systems, whilst evaluating compliance in practice against national standards and expectations, did not appear to detect issues relating to Ms A's care and treatment;
- findings from internal investigations were not being addressed within reasonable timescales;
- there was inadequate monitoring or follow up of whether staff had attended core areas of training, such as the Care Programme Approach and risk management. However the Trust asserts that 'Did not Attend' notifications were always sent to managers on a monthly basis from 2010.

2.53. Whilst the staff interviewed commented clearly on their clinical supervision experiences these did not fully reflect the overall Trust framework for clinical supervision. The Trust has a central list of clinical supervisors which staff can access via the intranet to identify a suitable supervisor. This list comprises in-house staff who have completed the Trust's approved Clinical Supervision for Supervisors course. As part of the Trust's Appraisal/Personal Development Review process managers should confirm that staff are in receipt of clinical supervision and discuss any development needs that have arisen during clinical supervision. This information also forms part of the PDR form which managers complete to confirm supervision is

being received by clinicians as per Trust policy. The supervision policy requires the supervisor and supervisee to complete a supervision contract/agreement and then maintain supervision record sheets for each session. These should be filed in the individual's professional portfolio.

Conclusions

2.54. This Investigation concluded that Ms A was in receipt of a comprehensive package of care, which was supporting her to achieve recovery and independence. The recovery support services and supported housing available to Ms A were impressive, and they together with statutory mental health teams were working towards Ms A's recovery.

2.55. Unfortunately this Investigation found that despite these strengths there were some serious underlying weaknesses in the underpinning safety net of care. Significant omissions existed in relation to risk assessment and management and the limited way in which the Care Programme Approach and Care Coordination was put into practice. The test of a good package of care and treatment cannot depend solely upon the quality of provision when things are going well and a service user is in a state of recovery. The test also has to apply when a service user relapses and enters a state of crisis. In the case of Ms A the care and treatment package that worked well when she was in recovery, failed to provide for her continued health, safety and wellbeing when in relapse.

3. Recommendations set by the Independent Homicide Investigation

3.1. The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

3.2. The Independent Investigation Team worked with the Dorset Healthcare University NHS Foundation Trust and Bournemouth Local Authority Social Services to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice has been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this investigation process.

Recommendations 1 and 2: Medication and Treatment

- ***Service Issue One. Ms A's continued non-compliance with medication was a significant part of her risk presentation. The failure to develop an explicit medicines management plan was poor practice. The treating teams appear not to have understood compliance and non-adherence issues and this is a significant point of learning for the Trust when engaging service users such as Ms A in the future.***

- ***Contributory Factor One. The absence of structured involvement of family and the failure to engage the family in either education or***

therapeutic interventions as recommended by NICE guidelines was a serious omission. This omission ensured that identified family dynamic issues were not addressed and that Ms A's parents did not understand her in the context of her mental illness. This contributed to the less than optimal management of Ms A's care and treatment.

Recommendation 1. The Trust will provide training to Community Mental Health Team staff on Medicines Management Planning; this will cover compliance and non-adherence and will incorporate motivational interviewing skills. The Trust will instruct clinicians of the importance of documenting the reason behind decisions to change treatment, either medication or psychological and social intervention, so that not only is the decision recorded but the reasons underpinning the decision are recorded.

Recommendation 2. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and publicise the role of the Recovery Education Centre in supporting Carers and Families.

Recommendation 3: Care Programme Approach

- ***Contributory Factor Two. The Care Programme Approach is a mechanism that should ensure the coordination of care for mental health services users with severe and enduring mental illness. In the case of Ms A lip service only was paid to the Care Programme Approach and when she relapsed the safety net of care that should have been provided failed to operate. This made a direct contribution to the multiagency lack of understanding regarding Ms A's crisis plan in August 2010. It also contributed to the delays which ensued in ensuring Ms A's mental state was assessed and managed in an appropriate and timely manner.***

- ***Service Issue Two. The Trust Care Programme Approach Policy was not implemented appropriately in the case of Ms A over a seven-year period. This is evidenced by Ms A's extant clinical documentation and from clinical witness interviews. This lack of implementation is problematic and represents a significant point of learning for the Trust.***

Recommendation 3. The Trust will review the Care Programme Approach Policy including the specific requirements for Patients on Community Treatment Orders. The Trust will provide training to all staff of Community Mental Health Teams on the revised policy. The Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- holistic needs assessments are conducted;
- care plans are developed, monitored and reviewed;
- carers and service users are involved fully (where appropriate) in the process;
- primary care practitioners are sent copies of all relevant documentation;
- specific management plans are in place when a person is placed on a Community Treatment Order.

Recommendation 4: Clinical Risk Assessment and Management

- ***Contributory Factor Three: Clinical Risk Assessment and Management practices were uni-disciplinary, poorly documented, and poorly shared between agencies. The consequence of this was that not all involved in caring for Ms A understood what her latent risks were and what to do if they became manifest. This contributed to the poor management of her deteriorating mental health leading up to the death of her mother.***

Recommendation 4. All staff from Community Mental Health Teams will be trained in the revised Clinical Risk Policy. The Trust will review and ensure that clear guidance and protocols are in place with partner agencies to ensure that information pertaining to increased risk and significant change is communicated in a robust manner and documented in the RiO record. The Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- risks are assessed at a frequency in accordance with Trust risk and CPA policy documentation;
- all identified risks are managed by comprehensive risk plans;
- relapse and crisis and contingency plans are updated in accordance with service user need and are communicated widely to all members of secondary and primary care-based care and treating teams.

Recommendation 5: Carer Assessment and Involvement

- ***Contributory Factor Four. There was a failure to effectively involve the family in the Care Programme Approach. There was also a failure to provide them with education about Ms A's illness, risk presentation, relapse indicators and crisis plan. As a consequence Ms B did not have the awareness, knowledge or understanding to effectively and safely respond when her daughter started to relapse.***

Recommendation 5. The Trust will ensure that each Community Mental Health Team has a Carer's Lead to champion the needs of Carers and their families. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and publicise the role of the Recovery Education Centre in supporting Carers and Families.

Recommendation 6: Housing

- ***Service Issue Two. The lack of availability of long-term supported tenancies can cause a degree of uncertainty for vulnerable people. This 'move on' culture is not always in the interests of their health, safety and wellbeing.***

Recommendation 6: The Trust will work with the Local Authority to participate in a scoping exercise of housing need, reviewing need against current provision. The Trust will work with the Local Authority to use this information to develop a Mental Health Housing Strategy to include a strong focus on individuals with severe and enduring mental health needs.

Recommendation 7: Documentation and Professional Communication

- ***Service Issue Three. There was an absence of information-sharing protocols between third sector organisations and the Trust. This prevented 'joined up' working both in ongoing care, and crisis situations.***

Recommendation 7. The Trust will develop new Information Sharing Protocols for each Third Sector Organisation that jointly provides care with the Trust. These protocols to be audited for effectiveness as part of an ongoing audit process.

Recommendation 8: Policy Adherence

- ***Service Issue Four. Poor policy and procedure adherence was in evidence which impacted upon the quality of the care and treatment delivered to Ms A.***

Recommendation 8. The Trust will review its systems for informing teams of new/revised Policies and Procedures. The Trust will develop a revised management and clinical supervision policy that takes account of adherence to new Policies and Procedures.

Recommendations 9, 10, 11, 12: Overall Management of the Case

- ***Contributory Factor Five. The absence of an effective CPA care planning and coordination process ensured multiagency and disciplinary communication and relationship building was managed poorly. This laid the foundations for people not knowing what to do, or getting an effective response, when Ms A was reported as being in crises. This made a direct contribution to the failure to manage Ms A in an effective and timely manner between 23 and 25 August 2010.***

- ***Contributory Factor Six. The practice of not asking the Crisis and Home Treatment Team to assess clients in crisis before the CMHT team had seen them contributed significantly to the decision not to provide additional support or assess Ms A within 24 hours or sooner.***

- ***Contributory Factor Seven. The absence of clear operational plans regarding the use of the CTO in the event of Ms A's relapse contributed to the failure to discuss the case with the Responsible Clinician; this prevented his timely involvement and ability to intervene.***
- ***Causal Factor One. Not providing an assessment and suitable intervention within 24 hours ensured Ms A's mental health continued to***

deteriorate, thereby ensuring that she became an increased risk to herself and others. Based upon what was known, and should have been known about Ms A, a rapid response was indicated. The failure to provide the assessment and intervention that she required led to her mental health deteriorating and her risks remaining unmanaged. Consequently Ms A's mental health continued to deteriorate to the point where she killed her mother.

Recommendation 9. The Trust will ensure that all Community Mental Health Teams are instructed of the referral routes to the Crisis and Home Treatment Team and of the role that Duty Workers have in managing patients who require urgent assessment or intervention. The Trust will ensure that all Service Users on Community Treatment Orders are discussed as a minimum on a monthly basis within Team Meetings and that a record of the discussion is recorded in the RiO system. The Trust will also review all Operational Policies and care pathways to ensure that referral and access to Crisis Team is made explicit to:

- primary care workers;
- secondary care workers;
- third sector workers;
- services users;
- carers and families.

Recommendations 10 and 11 set by the Local Authority

Recommendation 10. The Safeguarding Adult Board (SAB) and the Trust at Board/leadership level to understand and define the relationship between adults at risk by reason of their mental health issues and those at risk within the broader definition and therefore oversight of adult safeguarding. The SAB to communicate and train relevant staff when that understanding has been reached and agreed.

Recommendation 11. The SAB to debate and agree the extent to which adult safeguarding protocols and procedures are/should be the backstop for service failures elsewhere in the system.

4. Comparisons between the Ms A investigation and the later Ms X Investigation

4.1. The Homicides perpetrated by Ms A and Ms Y took place in August 2010 and July 2012 respectively. The Ms Y Investigation was commissioned in May 2014 – nearly four years following the death of Ms A's victim. This meant that the Investigation for Ms Y and its findings had a direct bearing upon the examination of the progress made in relation to service improvement and the recommendations from the Ms A Investigation.

4.2. There were several areas of findings that bore similarities between the two separate cases even though they were separated by a period of four years. These were:

1. **CPA:** CMHT's did not follow Trust policy guidance in relation to the Care Programme Approach. There was a poor understanding of policy and procedure and the role of the Care Coordinator was understood poorly. Processes were neither multidisciplinary nor Multiagency.
2. **Clinical Risk Assessment.** Risk assessment and management processes were poor and did not adhere to Trust policy expectation. Interagency risk assessment and information sharing processes were weak leading to missed opportunities and a lack of robust communication and risk management.
3. **Interagency Working.** This was identified as being weak especially in relation to risk assessment and information sharing. Organisations tended to work in silos and did not place the service user at the centre of the care pathway.
4. **Carer Assessment and Involvement.** There were issues across both cases whereby carers were not kept informed about the service users' conditions. In the absence of an active engagement and education programme carers were unable to understand and support their loved ones in an optimal manner.
5. **Professional Communication.** These processes were found to be weak and acted as a barrier which prevented joined up working.

5. Progress Made Against the Ms A Recommendations

5.1. By the time the Ms Y Investigation came to a close in 2015 it was evident that the Trust had made significant progress across many areas pertinent to both the Ms A and the Ms Y recommendations. At a lessons for learning workshop held on 12 August 2015 the Trust stated that all of the Ms A recommendations had been met. Progress regarding the Ms A Investigation recommendations was evidenced though:

- Interviews with clinicians and managers for the Ms Y case as a triangulation exercise.
- Documentary analysis.
- A learning event facilitated with the Trust held by Jon Allen the Chair of the Ms A Investigation on 1 April 2014 – this served to review recommendations and progress directly after the publication of the report.
- A lessons for learning workshop held with the Trust and commissioners of service on 12 August 2015.

Governance

5.2. In order for an NHS Trust to make sustainable changes and improvements to services robust governance arrangements have to be in place. Over the past four years the Dorset HealthCare University NHS Foundation Trust has undergone a major governance and system modernisation process. This process has focused upon how the organisation learns from incidents and also how it assures and audits appropriate and safe service delivery.

5.3. Since 2012 Dorset HealthCare has been subject to significant challenge and transformation. The organisation was independently scrutinised and found to be failing in a number of areas critical to ensuring high quality care for patients.

Between June 2011 and April 2013 the Care Quality Commission (CQC) inspected 14 Trust sites. Four locations were assessed as fully compliant and 10 sites were assessed as noncompliant with a number of the essential standards assessed. Several locations were found to be non-compliant on successive visits, with significant failings in some areas (notably Forston Clinic and Blandford Hospital).

5.4. There was a lack of response from the then leadership in responding to CQC concerns regarding significant gaps in governance and assurance. This resulted in Monitor taking enforcement action. In April 2013 Dorset HealthCare was found by the regulator Monitor to be in breach of its licence conditions and subject to Enforcement Undertakings to address a number of failings identified by the Care Quality Commission. A review by Deloitte LLP during May and June 2013 found that the Board needed to address the significant challenge of bridging the cultural gap between legacy organisations. The Trust responded with an Action Plan in August 2013, which, in conjunction with the outcome of the Deloitte Governance Review, led Monitor to conclude that the Trust board was failing to take sufficient action to secure a return to compliance with its licence conditions. As a result, Monitor imposed an additional licence condition on 4 September 2013 relating to governance requirements.

5.5. A more substantial Trust Recovery Plan was established in September 2013. The plan comprised a total of 331 actions, which included tasks and actions from the Deloitte review (253 actions), further actions identified internally by the Trust, plus actions in response to the CQC Outcome 16 review (April 2013).

5.6. On the 17 June 2014 Monitor issued the Trust a certificate of compliance confirming the Trust was no longer in breach of its licence condition and was now content with the leadership of the organisation and was satisfied that the leadership will do the right things but, recognised also, how much work needs to be done.

Locality Restructure

5.7. In 2012 the Trust managed the delivery of operational services through three directorates - mental health, community services and children and families, led by a Service Director. Over the past year the Trust has recognised that it has reached the limits of what it can achieve within existing service delivery and structural constraints, and the way in which it has worked historically will, if continued, impede development of truly integrated and community-specific services. In particular, the Trust will not be able to deliver the high quality it is seeking.

5.8. The Trust is now in the process of implementing a transformational restructure moving from a business model that was service and speciality-led to one that is locality-led, in line with current innovative thinking in mental health and community services. The Trust is now implementing a locality-based service delivery model and a locality management structure that will enable clinical teams to operate at a local level, in conjunction with key GP and local authority partners.

5.9. This new model encompasses all the services currently offered by the three Directorates (Mental Health, Community Health Services, Children and Young People). Care will be delivered via three ‘super localities’ (Poole, Bournemouth and Dorset), which will further subdivide into 13 localities based on GP locality

boundaries. This will ensure that decisions are made locally and are tailored to the specific requirements of each area. The management structure of the locality care model is designed to improve patient experiences and the quality of our care offering. The Trust believes that the adoption of a locality-based model will deliver significant service quality and experience improvements, as well as broader financial and commercial benefits.

An Overview of how Clinical Governance Works Now

5.10. The management and governance of the Trust has changed and is still in transition. Trust Executive Group was established in October 2013 to meet on a monthly basis. This group brings together senior and key clinicians and Directors in a unique forum that focuses on the strategic direction of the Trust, looking across physical and mental wellbeing and across all ages. The following has been achieved:

1. The establishment of a Serious Incidents Requiring Investigation Panel, chaired by the Medical Director. Clinical teams present their RCA review findings to the panel (Medical Director, Director of Nursing and Quality, Head of Patient Safety and Risk), and review the learning identified and agree recommendations. The Clinical Effectiveness and Regulation, Patient Safety and Patient and Carer Experience groups report to the Quality Assurance Committee on matters relating to Quality and Patient Safety.
2. The Trust has been engaged with the South West Quality and Patient Safety Improvement Programme on a variety of topics such as pressure ulcers, catheter acquired infections, management of the deteriorating patient, Safe wards in Mental Health, falls and suicide reduction. With the establishment of the Academic Health and Science Networks (AHSN) the Trust are engaging with the Wessex AHSN.
3. Integrated Dashboard – the Trust has done much to improve the monitoring and reporting of performance at team, Directorate, Committee and Board level, taking best practice into consideration as highlighted in the Monitor Quality Governance guidance. The integrated corporate dashboard has been significantly updated to include directorate performance set against updated quality metrics, as well as overall Trust performance that is now tracked with trend analysis over a 13 month period.
4. Patient safety issues continue to be reported in the monthly Quality Report. The National Reporting and Learning System (NRLS) sends regular reports in relation to all patient safety incidents that have been reported by the Trust - including rate and frequency of reporting, level of harm and type of incident and this is reviewed by the Directors. The report shows that the Trust is a high reporting organisation with larger numbers of no/low harm, which demonstrates an open culture of reporting all incidents. All incidents continue to be reported on a monthly basis from ward/team to Directorate and the Patient Safety Meeting. A Quality Newsletter has been developed for front line staff in order to share and promote Quality and Patient Safety topics.
5. The Trust continues to be an active member of the local Child and Adult Safeguarding Boards and sub groups and works in an integrated way to develop a holistic family approach to safeguarding.
6. The Trust has established a NICE assurance group, co-chaired by the Medical Clinical Audit lead and the Head of Clinical Effectiveness to gain full assurance of

NICE compliance and to ensure the guidance is well understood by Trust staff and evidenced in practice.

7. The Trust's Annual Clinical Audit programme has been developed taking into account; learning from internal and external events, the Clinical Audit Programme Guidance Tools published by Healthcare Quality Improvement Partnership (HQIP), NICE baselines, contractual agreements, national clinical audits and CQUIN agreements.

The Trust's Blueprint Document (2014 – 2015)

5.11. The Trust has developed a Blueprint Document. This document sets out in a detailed action plan how the organisation will move forward in the future and improve patient services. The purpose of The Blueprint is to record how Dorset HealthCare responded to significant failings in both governance and in the quality of patient care in its plans and ambition for the future, to become an exemplar in the delivery of personalised, integrated care in localities.

5.12. The Blueprint explains how during 2014/15 the Trust would undertake a programme of Governor, staff and wider stakeholder engagement to refresh its vision, articulate its organisation's purpose, reaffirm its values and renew its strategic objectives.

5.13. It identifies the six key themes where the Trust continues to develop towards organisational excellence and signposts the more detailed strategies and plans that will follow:

- Board and leadership development;
- Organisational development and its people;
- Governance, quality and risk management;
- Staffing;
- Performance and information reporting;
- Partnership working and participation.

5.14. The Blueprint sets out thirty-six deliverables; thirty-two were completed by 30 April 2015 leaving four ongoing. Of the four deliverables yet to be completed two are waiting papers to go to the Board (The *Estates Strategy* and the *Performance measures for the new Strategic Plan*) and therefore RAG rated Amber/Green. The remaining two rated Red are the; *To carry out a root and branch review of Recruitment and Retention*, although a lot of work has been undertaken in this area recruitment and retention are still a major risk for the Trust. Again, although a lot of work has been undertaken in *Review of Mandatory Training*, as of March 2015 the Trust has a compliance rate of 91.19 percent against a target of percent.

5.15. The top ten risks identified within The Blueprint have been evaluated and, within the wider piece of work on risk management undertaken last year, have been incorporated into those systems where still relevant. In January 2015 the Trust Board approved its refreshed Strategy 2015-2020. The six key themes in The Blueprint are areas that will continue to be taken forward and monitored within this framework. For the purpose of this update there are two areas of specific relevance to the governance and quality improvements that the Trust has taken forward:

Governance, Quality and Risk Management

5.16. From the beginning of June 2014, PM Governance worked with the Trust to develop risk management, assurance processes and governance arrangements across the Trust. This work was summarised at the September 2014 Board workshop and a number of key decisions about future governance arrangements were agreed.

5.17. The Implementation Steering Group oversaw delivery of key decision points through to the Board which 'went live' on the 1 April 2015. The work with PM Governance has now been completed and the Trust is implementing and embedding the revised risk and quality assurance processes. Chief Risk Officer responsibilities are split between the Director of Nursing & Quality (clinical risk) and the Trust Board Secretary (non-clinical risk).

5.18. Embedding of assurance processes via Board Committees is underway and it is acknowledged that this is not a quick fix. Milestones have included:

- a Trust Board Workshop on risk horizon scanning with the output set out in a strategic risk plot, to more readily identify the strategic risks for new financial year. This facilitated the population of the Board Assurance Framework (BAF) for 2015/16, and the acquisition of assurances throughout the year from internal and clinical audit teams. This process and full Board involvement and engagement has given confidence about the design and operation of controls which mitigate these significant risks;
- between January and March 2015, agreement by the Audit Committee of the internal audit programme for 2015/16 and by the Quality Assurance Committee of the Clinical Audit Plan. The Audit Committee reviewed both plans in March 2015;
- a revised Risk Management Policy approved by the Executive Quality and Clinical Risk Group and Executive Performance and Corporate Risk Group in February 2015, noted by the Audit Committee in March;
- the senior groups of the Executive as from 1 April 2015 are the Executive Quality and Clinical Risk Group and an Executive Performance and Non-Clinical Risk Group. These Groups have been forming over the past two months and are now established and operational working to their Terms of Reference;
- as from 1 April 2015 two Assurance Committees reporting to Board; the terms of reference of these and the Executive's senior groups will be reviewed by the steering group on 19 November 2015;
- the introduction of letters of assurance from Assurance Committee Chairs to the Trust Chair at the end of each financial year, setting out their review of assurances of control systems during the year. Letters of management representation by Executives and their direct reports to the Chief Executive about disclosure of quality failings and unmitigated risks has been discussed but will not be introduced yet.

Conclusions

5.19. At the time Ms A was a service user with the Trust it was evident that significant policies were not adhered to and this compromised the effectiveness and quality of the care and treatment that they received. The Independent Investigation concludes that no single practitioner was responsible for this because systems were inadequate

and failed to ensure staff had a clear understanding of what was expected of them. This was compounded by poor staffing levels, heavy caseloads and a monitoring and regulation process that was too weak to detect failings.

5.20. As has been discussed above, the Trust was found to be failing against key national governance standards. Since this time a great deal of work has been done in conjunction with external regulation and inspection to ensure that the organisation is functioning in keeping with the standards set by Monitor and the Care Quality Commisison. We understand that significant improvements have already taken place and that work is currently in train to ensure policy compliance and a corporate approach to patient safety and quality care is implemented and maintained. There should be an increased confidence in the organisation to learn form incidents and to ensure patient safety.

Medication and Treatment (Recommendations 1 and 2)

Recommendation 1. The Trust will provide training to Community Mental Health Team staff on Medicines Management Planning; this will cover compliance and non-adherence and will incorporate motivational interviewing skills. The Trust will instruct clinicians of the importance of documenting the reason behind decisions to change treatment, either medication or psychological and social intervention, so that not only is the decision recorded but the reasons underpinning the decision are recorded.

5.21. The Trust reported to HASCAS that medicines management training incorporating compliance and non-adherence factors has been supplied to all CMHT team leaders and representatives together with CMHT leads for medication management. This approach included motivational interviewing skills. Over 95% of the target audience attended the training.

5.22. A medicines adherence audit was conducted for all service users on Community Treatment Orders (CTOs). Care plans for compliance and non-adherence were subsequently put into place where clinically indicated. A CTO care plan template has been added onto RiO (the electronic record system) and all service users on CTOs are now discussed as a minimum on a monthly basis within all CMHTs.

5.23. Medics recording rationale for change of treatment within the patient record is now an embedded practice. The Director for Mental Health wrote to Associate Managers and Lead Consultants requesting that the recommendation be discussed at all management groups and ward and team meetings across the Mental Health Directorate. At the time of preparing this report compliance stood at 97.44%. This particular recommendation remains a part of the ongoing Trust clinical audit cycle.

Recommendation 2. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and

publicise the role of the Recovery Education Centre in supporting Carers and Families.

5.24. The Psychosis Pathway was developed and launched at the CMHT Essential Standards day on 1 October 2013. The pathway includes clear links to the role of the Recovery Education Centre who have worked with the Dorset Mental Health Forum to devise courses to support carers of people with mental health issues. A review of the family work services was undertaken to establish that all concerned were trained appropriately.

5.25. An audit of the pathway implementation was carried out in March 2015. Family interventions are now in place and in accordance with NICE guidance. Progress will be continuously monitored.

Care Programme Approach

Recommendation 3. The Trust will review the Care Programme Approach Policy including the specific requirements for Patients on Community Treatment Orders. The Trust will provide training to all staff of Community Mental Health Teams on the revised policy. The Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- **holistic needs assessments are conducted;**
- **care plans are developed, monitored and reviewed;**
- **carers and service users are involved fully (where appropriate) in the process;**
- **primary care practitioners are sent copies of all relevant documentation;**
- **specific management plans are in place when a person is placed on a Community Treatment Order.**

5.26. CTO guidance has been sent to every single member of CMHT staff across the Trust. The CPA policy was amended to specifically include:

- the conditions of CTO;
- minimum frequency for patients to be seen;
- circumstances to initiate recall;
- early warning signs;
- others to be alerted in the event of relapse.

5.27. By 17 December 2014 97% of Trust staff had been trained. Training in this area was provided as follows:

- CPA roadshows;
- 1:1 meetings with Care Coordinators of service users on CTOs;
- CPA review packs were rolled out to all teams and put on the Trust intranet;
- Specific CTO training sessions.

5.28. A CPA review audit standards tool kit was agreed. An audit of CPA standards was conducted following the publication of the Ms A report. Another audit was conducted in November 2014 the results were:

- 38% evidence of communication with primary care following CPA review; of which
- 100% provided an update of events and 100% provided an updated management plan;
- 83% of service users' views were recorded on the CPA plans.

5.29. The Trust proposal is to continue to audit CPA on a quarterly basis via the care planning quarterly audit and care plan dashboard system. A Care Plan Task and Finish Group has been established to develop a care plan audit and the care plan dashboards currently in use. This should increase performance and compliance.

5.30 The Trust has made significant progress in this area since the time of Ms B's death. Services have now changed in relation to the DBT approach and work has been ongoing to ensure full compliance with Trust CPA expectations. It has been a significant finding of the Independent Investigation that historic poor CPA practice was exacerbated by a culture of poor policy compliance.

5.31. The Trust now has in place a comprehensive process of audit which monitors CPA and risk assessment compliance. Compliance can be tracked to each individual clinical team and dashboard findings are made available on a monthly basis. The data from current audits suggest that the Trust is achieving a 95 - 100 per cent success rate.

5.32. The Trust is not only monitoring compliance in relation to the CPA process - it is also actively managing quality. As has been set out in the notable practice section above - a detailed CPA guidance toolkit is available to all staff which is supported by training update programmes. This approach sets out the Trust's expectation clearly together with practical advice as to how to achieve CPA policy requirements and best practice guidance.

5.33. HASCAS has been able to access significant evidence regarding CPA service improvement and following discussion with NHS Dorset Commissioning Group concludes that significance progress has been made.

Clinical Risk Assessment and Management

Recommendation 4. All staff from Community Mental Health Teams will be trained in the revised Clinical Risk Policy. The Trust will review and ensure that clear guidance and protocols are in place with partner agencies to ensure that information pertaining to increased risk and significant change is communicated in a robust manner and documented in the RiO record. The Trust will conduct an audit to ensure compliance with the revised policy within 12 months of the publication of this report to provide assurance that:

- **risks are assessed at a frequency in accordance with Trust risk and CPA policy documentation;**
- **all identified risks are managed by comprehensive risk plans;**
- **relapse and crisis and contingency plans are updated in accordance with service user need and are communicated widely to all members of secondary and primary care-based care and treating teams.**

5.34. Clinical risk assessment is now subject to regular compliance audits in the same manner as CPA. Currently the Trust has a 95% compliance rate; the figures for which are endorsed by NHS Dorset Clinical Commissioning Group.

5.35. There has been a review of the risk training mental health programme with the production of a clear pathway. Risk training has been delivered and some 900 staff have attended the following courses:

- the revised clinical risk update day;
- CMHT locality-based sessions provided by the Medical Director and Head of Patient Safety and Risk in the west of the county;
- Training sessions on the revisions to the Trust policy including the Essential Standards in the east of the county;
- RiO training sessions linking the system with the clinical risk policy requirements across mental health services. Safeguarding training was incorporated so that staff could consider the impact between mental illness and the potential for violence;
- 1:1 meetings with CCOs of service users with CTOs with the Head of Patient Safety;
- Ms A learning event held on 1 April 2014.

5.36. Partner Agency working had been taken forward in 2009 by the development of a Multiagency Pan Dorset Information Sharing protocol. Signed agreements were in place however the Spectrum Housing provider was not included. An audit was undertaken in October 2014 which showed that some 60% of relevant risks had been identified in a multiagency manner and that 33% had been recorded with risk having been shared appropriately. Consequently these results have been shared with CMHT managers and risk sharing protocols have been paced on the Trust internet. This has led to improved communication with partner agencies and the third sector. There is an acknowledgement that the new Adult Care Pathway will address to a large extent interagency and inter-service operational issues.

5.37. Additional progress has been made in relation to the RiO risk summary and additional training has been made available to staff (see above). The CMHT have also set up a process for teams to peer review the quality of a random sample of risk assessments across the service.

5.38. Crisis and care planning are now in place with compliance running at around 96% for care plans, 84% for crisis plans and 96% for risk assessment. Audit is being run across the Trust on a quarterly basis. All CMHTs have been reminded of the referral routes to the Crisis and Home Treatment Team and the role of Duty Workers in the management of service users requiring urgent assessment and intervention.

Carer Assessment and Involvement

Recommendation 5. The Trust will ensure that each Community Mental Health Team has a Carer's Lead to champion the needs of Carers and their families. The Trust will develop and implement a Care Pathway for Psychosis that will include the provision of family interventions in accordance with NICE guidance. As part of this the Trust will continue to promote and publicise the role of the Recovery Education Centre in supporting Carers and Families.

5.39. The Trust has produced a role specification for the CMHT Carer Lead. There is now facilitated group of carer leads working across the organisation. Clear standards have been developed for this role. A Carer Strategy has now been developed to support this work on an ongoing basis.

Housing

Recommendation 6: The Trust will work with the Local Authority to participate in a scoping exercise of housing need, reviewing need against current provision. The Trust will work with the Local Authority to use this information to develop a Mental Health Housing Strategy to include a strong focus on individuals with severe and enduring mental health needs.

5.40. Bournemouth Borough has completed a full review of the Mental Health Supported Housing Provision A strategy has been developed and approved. Due to procurement processes the document was due to go out to tender in 2015. As a result of the review the intention is to reshape the Mental Health Supported Living pathway with an increase in the provision of high support and step down accommodation. Supported Housing will remain temporary accommodation in that it is designed to enable people to learn and develop the skills required to live as independently as possible and the intention is to remove the arbitrary two-year move in period. The intention is to support people to move on as and when they are able to do so, this acknowledges that some people might be able to move on in a year, others may take three. The intention is to provide accommodation and review this every six months within the context of their support plan and this will ensure that people are accommodated in the appropriate place with the appropriate level of support. Where someone is ready and able to move on they will be supported to do so and where the individual is not yet at that point their tenancy will be renewed for a further six months and so on. There will be an expectation on the providers to move on an agreed percentage number of clients because there is a need to ensure that the services are enabling people to move on when they are able.

Documentation and Professional Documentation

Recommendation 7. The Trust will develop new Information Sharing Protocols for each Third Sector Organisation that jointly provides care with the Trust. These protocols to be audited for effectiveness as part of an ongoing audit process.

5.41. Please see risk assessment section above.

Policy Adherence

Recommendation 8. The Trust will review its systems for informing teams of new/revised Policies and Procedures. The Trust will develop a revised management and clinical supervision policy that takes account of adherence to new Policies and Procedures.

5.42. The Mental Health Directorate has identified the core policies for specific service areas which staff in those areas are expected to be familiar and implement in their

day-to-day practice. Core policies have been included in an addendum to the Trust's Induction Checklist which is to be completed as part of the new joiners' induction process with their initial Contract of employment to be signed and stored in personnel files. Managerial and Clinical supervision is in place to ensure that staff are briefed and understand any changes or revisions to these policies. Implementation of the Induction Checklist was audited in October 2014 – this demonstrated 4% compliance. The Human resource Department have reviewed the process in order to identify new ways of working to address the existing barriers.

5.43. The Trust Board told HASCAS that the Senior Leadership Team has undergone immense change since the time of the incident. There has been increased investment in leadership training and clarity around competency requirements for leaders alongside a major reorganisation. Improved systems for the recording and monitoring of supervision are currently being developed. The Trust has revised its clinical supervision policy and this has been uploaded onto the intranet. The role of supervision in the adherence to Trust clinical policy has been made explicit.

Overall Management of the case

Recommendation 9. The Trust will ensure that all Community Mental Health Teams are instructed of the referral routes to the Crisis and Home Treatment Team and of the role that Duty Workers have in managing patients who require urgent assessment or intervention. The Trust will ensure that all Service Users on Community Treatment Orders are discussed as a minimum on a monthly basis within Team Meetings and that a record of the discussion is recorded in the RiO system. The Trust will also review all Operational Policies and care pathways to ensure that referral and access to Crisis Team is made explicit to:

- **primary care workers;**
- **secondary care workers;**
- **third sector workers;**
- **services users;**
- **carers and families.**

5.44. CTO refresher training was undertaken in October 2013. An audit demonstrated that by September 2014 100% of services users on CTOs had a care plan in place, 100% had a copy of their plan and 100% had been sent to the GP.

5.45. All CMHTs were communicated with in order to clarify the role of the Duty Worker and the referral route when service users are found to be crisis. Changes have been made to the Duty system and strengthened, auditable guidance is now in place (see directly below).

5.46. The following policies have been identified for review and have been amended to include referral and access routes to the Crisis Team if not already explicit:

- CMHT Operational Policy (January 2014);
- Crisis Team Operational Policy (February 2014);
- Assertive Outreach Team Policy (April 2104);
- IAPT Steps to Wellbeing Policy (July 2194).

Local Authority Safeguarding Processes

Recommendation 10. The Safeguarding Adult Board (SAB) and the Trust at Board/leadership level to understand and define the relationship between adults at risk by reason of their mental health issues and those at risk within the broader definition and therefore oversight of adult safeguarding. The SAB to communicate and train relevant staff when that understanding has been reached and agreed.

Recommendation 11. The SAB to debate and agree the extent to which adult safeguarding protocols and procedures are/should be the backstop for service failures elsewhere in the system.

5.47. Recommendation 10 has been included within the Bournemouth and Poole Adult Safegaurding Board Policies and Procedures sub-group work plan and the Education and Training sub-group work plan. These plans are overseen by the Board and are making progress.

5.48. The Bournemouth and Poole Safegaurding Adults Board discussed recommendation 11 on 11 June 2014. A discussion took place around the following questions:

- the role of the emergency Out of Hours social care team;
- do agencies have a clear escalation protocol?
- There should be a clear pathway of options;
- Different options are required in Own Homes as opposed to care Homes;
- Housing needs to be part of the process.

5.49. It was agreed that all agencies needed to be clear about when and how to use Out of Hours Mental Health Services. The Directors of Adult Services were tasked with taking action to check Out of Hours contracts. There is a need for all to understand Escalation Policies –this is to be built in to the audit tool which is to be completed by all agencies by the end of the year, to assess the level of knowledge and use of escalation policies. A Communications Strategy will include a role for the Board through Newsletter/Poster, raising the profile of the Board and raising awareness of how to alert.

6. Conclusions

6.1. HASCAS was sent numerous documents and audits to verify the changes and service improvements that have been made. These documents included:

1. Final CPA/Risk Assessment Audit;
2. Standards for Care Planning Document;
3. CPA Review Guidance Pack;
4. CPA Leaflet;
5. Mental Health Learning & Development pathway;
6. Mental Health Foundation Pathway;
7. Care Plan Tool Box documentation;
8. Carers Strategy.

6.2. Whilst this report relies heavily upon the Trust's self-reports HASCAS has been able to triangulate the progress made by:

- documentary analysis;
- interviews (throughout the Ms Y investigation);
- CCG governance processes;
- CQC and Monitor independent inspection and review.

6.3. HASCAS can find ample evidence to suggest that the Trust has made significant cultural and system changes. These changes have strengthened governance processes and lend confidence to the belief in the organisation's ability to action improvements and to monitor improvements and service developments into the future. Based upon the evidence the Trust appears to have made significant progress on the implementation of the recommendations set by the Ms A investigation report.

Appendix 1

Quality Governance Committee 20th May 2015
Update on HASCAS Action Plan

Author	Head of Mental Health
Sponsoring Board Member	Director, Bournemouth & Christchurch Locality
Purpose of Report	Update on Progress
Recommendation	The Board is asked to Note the report/Approve: 1. Audit Results
Engagement and Involvement	All Community Mental Health Teams & staff
Previous Board/Committee Dates	March 2015

Monitoring and Assurance Summary

This report links to the Strategic Goals	▪ To provide high quality care; first time, every time; ▪ To be a learning organisation, maximising our partnership with Bournemouth University and promoting innovation, research and evidence based practice; ▪ To have a skilled, diverse and caring workforce who are proud to work for Dorset HealthCare; ▪ To be a national leader in the delivery of integrated care;

	▪ To raise awareness within the Trust and externally of the impact that our work has on people and our environment, and take steps to reduce any negative effects.

I confirm that I have considered each of the implications of this report, on each of the matters below, as indicated:	**Yes**	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality	eg[✓]	✓	
Board Assurance Framework		✓	
Risk Register		✓	
Legal / Regulatory		✓	
People / Staff		✓	
Financial / Value for Money / Sustainability		✓	
Information Management &Technology		✓	
Equality Impact Assessment		✓	
Freedom of Information		✓	

1.0 Introduction

1.1 Following a Homicide Independent Inquiry undertaken by the Health and Social Care Advisory Service (HASCAS) a number of recommendations were made in regards to Care Programme Approach (CPA) reviews and risk assessments within Dorset HealthCare University Foundation Trust.

1.2 These recommendations relate to communicating with primary care, involving relevant parties, recording views, identifying unmet needs as well as the completion and documentation of accurate and timely risk assessments.

1.3 This re-audit was undertaken to ascertain the level of compliance to these recommendations and also provides evidence for recommendations within another serious incident TMAR action plan.

2.0 Standards

2.1 The following standards were audited to measure compliance against the recommendations:

- A face to face CPA review should take place on an annual basis.
- All relevant agencies engaged in the patients' health, social, housing and offender care should be invited to contribute to the review.
- An assessment or re-assessment of risk should be made at Care Programme Approach (CPA) reviews.
- The views of Service Users and where appropriate their carer(s) are recorded in the CPA Review.
- The CPA Review identifies service users unmet needs and a management plan developed to address these.

- A CPA review always results in a written communication to primary care with an update of events and an updated management plan.
- For patients subject to CTO, a CTO care plan should be in place that includes risk and relapse indicators, and this should be shared with the GP
- Risk assessments should be up to date, with a care plan in place to address any medium or high risks.
- Risks within the assessment should be clearly described and a formulation recorded
- A crisis and contingency plan should be in place and updated on an annual basis

3.0 **Methodology**

3.1 The following methodology was used:

- Dorset HealthCare University NHS Foundation Trust Performance Information Department produced a list of all service users who had been under the CPA process for more than 12 months.
- Auditor randomly chose 5 cases from each Older People and Adult Community Mental Health Team.
- A detailed review of the notes was completed for each case. This included scrutiny of the CPA (including Care Plan, CPA Review and CPA Distribution), Clinical Documentation, Progress Notes and Risk Assessments.
- Results were analysed by Business Manager including comparison with previous results and presented within audit report.

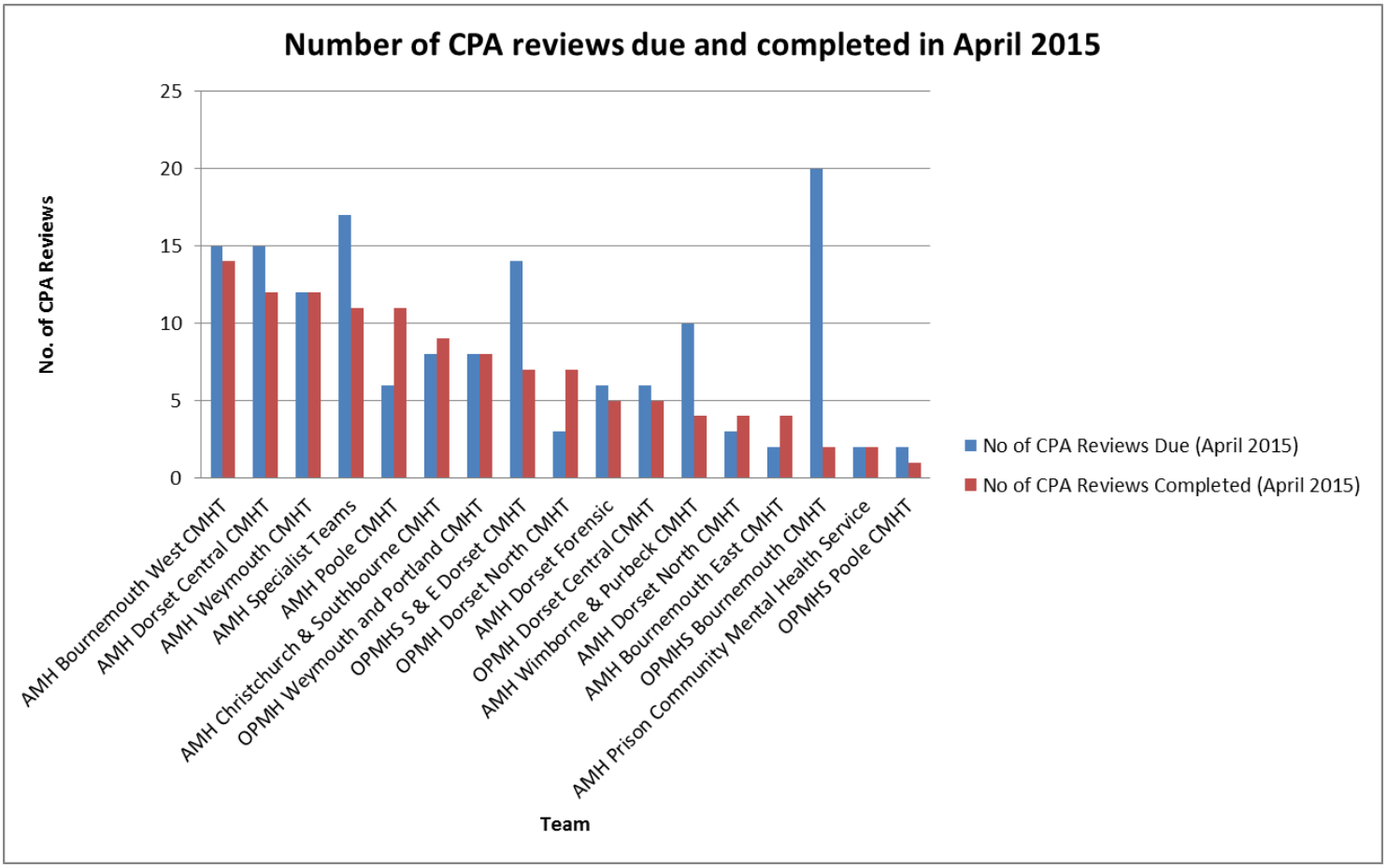
4.0 **Teams Audited**

4.1 A total of 118 CPA Reviews were undertaken during the month of April of which 79 cases were audited (67%).

4.2 The table below shows the number of Enhanced CPA clients, CPA reviews due in April 15, CPA reviews completed in April 15, and cases audited per service. (Please note this information cannot be split down to team level without manual validation).

	Enh CPA Team Caseload	No of CPA Reviews Due (April 2015)	No of CPA Reviews Completed (April 2015)	No of Cases Audited
AMH Bournemouth East CMHT	102	2	4	4
AMH Bournemouth West CMHT	200	15	14	5
AMH Christchurch & Southbourne CMHT	118	8	9	5
AMH Dorset Central CMHT	189	15	12	8
AMH Dorset Forensic	41	6	5	5
AMH Dorset North CMHT	98	3	4	4
AMH Poole CMHT	86	6	11	5

AMH Prison Community Mental Health Service	63	2	2	2
AMH Specialist Teams	190	17	11	7
AMH Weymouth CMHT	123	12	12	5
AMH Wimborne & Purbeck CMHT	112	10	4	4
OPMH Dorset Central CMHT	46	6	5	5
OPMH Dorset North CMHT	48	3	7	7
OPMH Weymouth and Portland CMHT	109	8	8	4
OPMHS Bournemouth CMHT	103	20	2	2
OPMHS Poole CMHT	23	2	1	1
OPMHS S & E Dorset CMHT	95	14	7	6
Grand Total	**1746**	**149**	**118**	**79**



4.3 The graph below shows the number of CPA reviews due and the number of reviews completed in April 2015 by service.

4.4 Please note unvalidated reviews from dates prior to April 2015 are included within the number of reviews due in April; however the validation of these reviews in April will not show as a completion against the month contributing to the greater number of reviews due than completed in the month.

4.5 For Bournemouth Older Person's CMHT a total of 20 CPA reviews were showing as due, of which 2 were completed within the month. This has been

raised with the team leader and service manager to ensure adequate systems are in place for the monitoring and completion of CPA reviews.

4.6 5 cases were audited per team where applicable. The table below shows the number of cases audited split by team:

Team	No of Cases Audited
AMH Blandford	2
AMH Bournemouth East	4
AMH Bournemouth West	5
AMH Bridport	3
AMH Christchurch & Southbourne	5
AMH Dorchester	5
AMH Poole	5
AMH Prison In-Reach	2
AMH Purbeck	2
AMH Shaftesbury	1
AMH Sherborne	1
AMH Weymouth & Portland	5
AMH Wimborne	2
AOT Bournemouth & Poole	2
Dorset Forensic Team	5
EIS East	2
EIS West	3
OPMH Blandford	2
OPMH Bournemouth	2
OPMH Bridport	1
OPMH Christchurch	5
OPMH Dorchester	4
OPMH Poole	1

OPMH Shaftesbury	2
OPMH Sherborne	3
OPMH Weymouth & Portland	4
OPMH Wimborne & Purbeck	1
Total	**79**

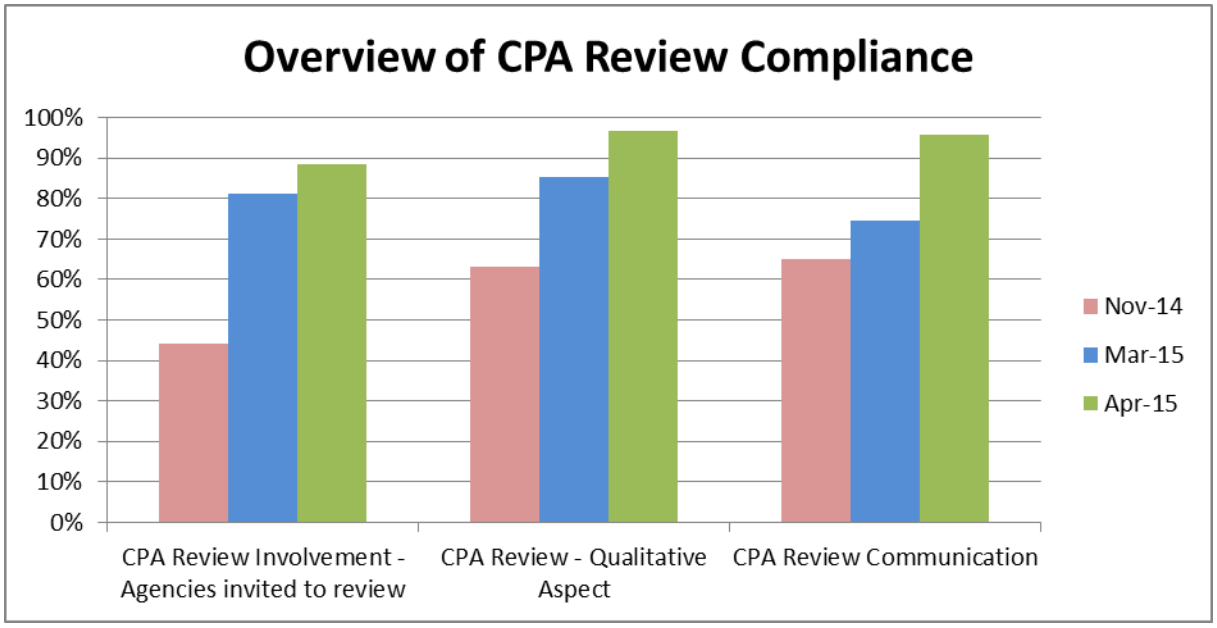
5 Key Findings

5.1 CPA Reviews - Overall there has been an increase across all standards audited relating to undertaking CPA Review's.

5.2 The 95% threshold was met for April. 100% of service users audited had a review as required.

CPA Review

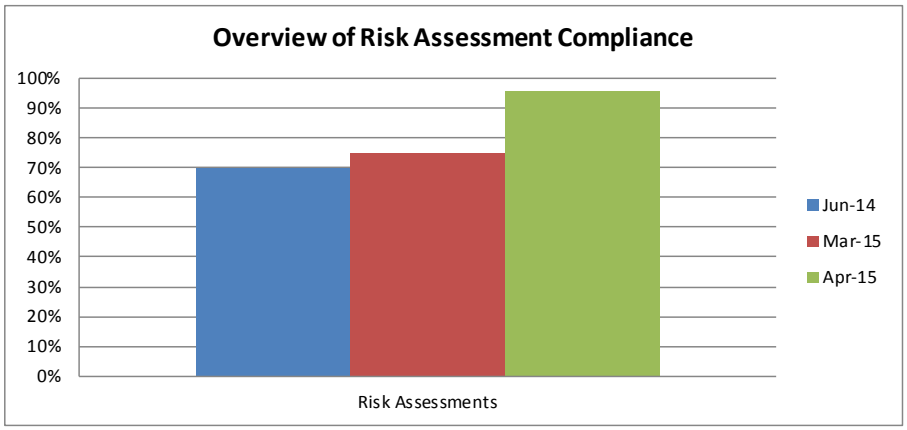
	Nov-14	Mar-15	Apr-15
Frequency of Review		97%	100%
CPA Review Involvement - Agencies invited to review	44%	81%	88%
CPA Review - Qualitative Aspect	63%	85%	97%
CPA Review Communication	65%	75%	96%
CPA Total	59%	83%	95%



5.3 Risk Assessments – this increased to 96% in April 15 and met the compliance threshold.

Risk Assessments

	Jun-14	Mar-15	Apr-15
Risk Assessments	70%	75%	96%

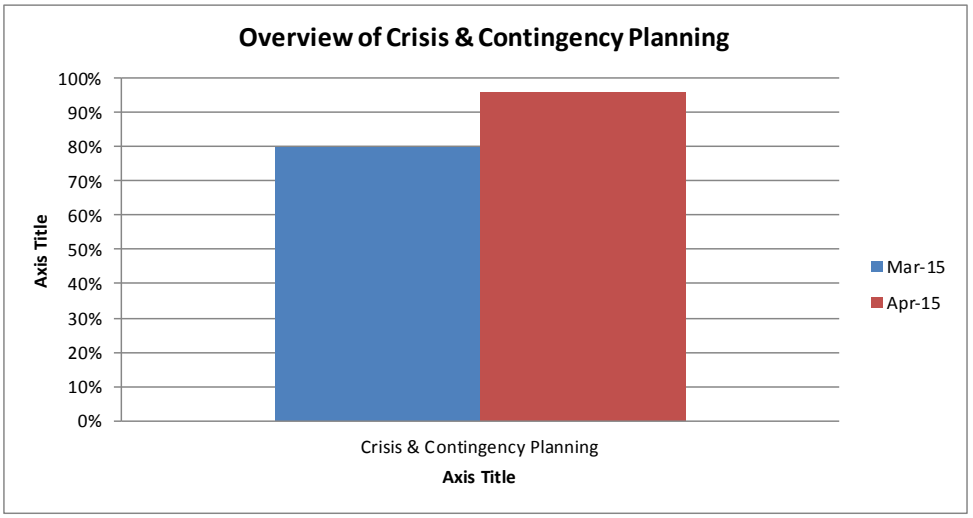


5.4 Crisis & Contingency Planning

5.5 There has been an increase in evidence of Crisis Plans in place and this exceeds the 95% threshold.

Crisis & Contingency

	Mar-15	Apr-15
Crisis & Contingency Planning	80%	96%



6 Summary

6.1 The audit for April 2015 met or exceeded the 95% threshold.