PROMOTING PATIENT SAFETY

A REVIEW OF CASES REQUIRING MENTAL HEALTH INDEPENDENT INVESTIGATION IN THE NORTH WEST

BETWEEN JANUARY 2002 – JULY 2006

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COMMISSIONED BY NHS North West

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1. EXECUTIVE SUMMARY

1.1 In July 2007 the Department of Health (DH) advised the Strategic Health Authorities (SHAs) to review the mental health independent investigations undertaken by the former SHAs between 2002 and 2006. These are referred to as the 'legacy investigations'.

1.2 This was to establish if all mental health incidents which met the criteria for independent investigation under the Health Service Guidance HSG 94(27) had received the appropriate level of independent scrutiny. The guidance requires that an investigation should be carried out by a panel which is independent of service providers and commissioners involved.

1.3 The 2005 guidance amendment, introduced flexibility to improve the timeliness of the investigations and encourage the introduction of root cause analysis (RCA) to support further learning and improvement This had resulted in differing interpretation by NHS organisations and it had become apparent nationally that not all cases may have been subject to appropriate independent scrutiny.

1.4 In responding to the DH advice, NHS North West set the context and approach for their review. The priority was to fulfil the SHA's responsibility to service users and carers, the families of the victims and the public to improve patient safety. The review of the legacy cases was an opportunity to

- learn the lessons of the past,
- ensure that practice and service improvements are implemented
- and inform the SHA's future management of independent investigations.

1.5 NHS North West commissioned an independent project team led by Dr Colin Dale to review the cases and make recommendations for further action. A review panel of independent expert clinicians was recruited to support the team (appendix one).

1.6 The relevant investigations were identified and the reports collated and assessed to ascertain the level of investigation which had already been carried out. (appendix two)

1.7 The project team and panel reviewed in detail forty two legacy mental health homicide investigations which had taken place between three and seven years ago. All investigation reports were subject to an audit by the project team (appendix three) and those nineteen investigations which it was determined had not met the standards required by HSG (94) 27 were subject to further consideration by the independent review panel of clinicians.

1.8 The audits and panel reviews identified areas of good practice and areas for improvement in relation to services provided by trusts at the time of the incident concerned. The panel recognised that since these incidents, services have been restructured, trusts have merged and current standards of professional practice and service delivery, including national guidance, are very different now.

1.9 Recurrent issues emerged from the case reviews and a thematic analysis was conducted which refined and validated the key themes.

1.10 As requested by NHS North West, the panel considered the option of recommending a further independent investigation for each case where this had not taken place. On balance, the panel decided against this approach on the grounds that:

- the time lapse since the incidents was such that many families would find further investigation distressing;
- staff would have moved on and would need to be traced or may be unavailable;
- service users had not given consent for their personal information or health records to be accessed or made public;
- as a result of this review, all cases had been subjected to further scrutiny by an expert panel and the root cause and contributory factors had been identified.

1.11 The review panel concluded that the families, service users and public interest would be best served by ensuring that lessons had been learnt and recommendations had been or were being implemented by the NHS organisations concerned.

1.12 Therefore, the review panel recommended that:

NHS North West should seek assurance from each Trust that it had implemented recommendations from relevant investigations, or had a clear action plan to do so. This would enable effort to be focussed on assurance that lessons had been learnt, changes made and risk reduced.

1.13 NHS North West accepted the panel recommendation.

1.14 The process for seeking assurances was agreed with the review team and trusts. Each trust received reports containing the recommendations and good practice identified from their individual cases; and recommendations arising from the thematic analysis conducted by the project team advising NHS North West.

1.15 The analysis identified thirteen key recurrent or significant themes from the reports. Therefore, in addition to seeking assurance regarding individual trust investigations, assurance was also sought from them in respect of the wider themes identified across the North West (appendix four).

1.16 Trusts were asked to provide these assurances in writing to the SHA. Formal feedback meetings were held between the SHA, panel representatives and trusts; the trust responses were discussed in detail and further refined by clarification and provision of additional evidence.

1.17 All trusts were able to assure the SHA that recommendations from their individual cases had been addressed.

1.18 An evaluation of trust responses to the thematic analysis was carried out. The trusts provided assurance that established policies, procedures and guidance were in place for the majority of the recommendations and in many cases, these were underpinned by audit programmes. In some cases, improvements were embedded with action plans to implement the audit recommendation.

1.19 Trust responses generated some common areas for further development and innovative practice in some areas, including involvement in national and regionally recognised work. The trust responses to the thematic analysis are appended to this report (five to twelve).

2. INTRODUCTION

2.1 The HSG 94 (27) confirms that the SHAs are accountable for commissioning independent investigation of serious untoward incidents in mental health under the following circumstances:

- When a homicide has been committed by a person who is or has been under the care of specialist mental health services, that is subject to regular or enhanced care programme approach, within the six months prior to the event
- When it is necessary to comply with Article Two of the European Convention on Human Rights if the state agent is or may have been responsible for the death or where the victim was in fear of their lives.
- If there is evidence of systematic service failure.

2.2 One of the underpinning principles of the guidance is that the investigation should be independent of both commissioners and providers of the service. In July 2005, the guidance HSG 94 (27) was revised, allowing flexibility for SHAs to adopt proportionate approaches to independent investigations. This was to enable the use of root cause analysis methodologies to promote learning and to ensure a timely investigation, so that changes could be made quickly and families could find out what had happened.

2.3 Following the establishment of new SHAs in 2006, it became apparent that, historically, there had been national variation in the interpretation of the HSG 94 (27) guidance. In some cases the investigations had been internal ones, but involving a degree of independence, rather than being independent of the commissioners and providers. Other investigations had been delayed during the reorganisation of the SHAs and PCTs.

2.4 In July 2007 the Department of Health advised the new SHAs to undertake a retrospective review of the mental health independent investigations undertaken by their predecessor SHAs between 2002 and 2006. This was to establish if all mental health incidents which met the criteria for independent investigation under HSG 94(27) had received the appropriate level of independent scrutiny.

2.5 Dr Colin Dale was commissioned by NHS North West to review the legacy cases, advise the SHA of the requirements for further investigation and support the development of the SHA's future management of independent investigation. The brief for the project agreed with NHS North West was:

- The development of an audit document to be used to assess the quality of the investigation reports
- A detailed analysis of each investigation report
- The requirement for any additional work needed as identified by the analysis of investigation reports
- The agreement of a governance framework for the future handling and reporting of independent investigations
- The establishment of a commissioning process for future independent investigations

This final report of the project focuses on:

- The audit and analysis of the legacy cases (phase one)
- The assurance work with trusts carried out as a result of the analysis (phase two).

2.6 In respect of phase one, this report provides an overview of the review methodology, the approach used by the review panels, the outcome and thematic analysis of the review findings. For phase two the report describes the process whereby the SHA sought assurances from the trusts that they had addressed the issues raised in their own cases, the key themes and the evaluation of those assurances.

PHASE ONE:

3. REVIEW AND ANALYSIS OF THE LEGACY CASES

3.1 IDENTIFYING CASES FOR REVIEW

3.1.1 All cases known to the SHA were listed and checked with the trusts. This was supplemented by a request to all the mental health trusts in August 2007 for information about any unlisted incidents or reports.

3.1.2 Forty two potential cases were identified, which were at different stages of investigation, reporting and publication. Seven cases did not meet the criteria for independent investigation. These incidents had been reported but further clarification confirmed that they were not homicides; were outside the time-scales for eligibility; or where there had been no involvement of specialist mental health services.

3.1.3 A further two were excluded from the review as they were undergoing full independent investigation. Of the remaining thirty three cases, twelve had been subject to full independent investigation and nineteen had been subject to an internal Trust investigation. Seven of these nineteen cases had been subject to a further degree of independent consideration but did not amount to full independent investigation. In the remaining two cases, the report was not available at the time of this project. Cases not included in this project are being managed under the NHS North West independent investigations procedures.

3.1.4 Appendix two contains a full, anonymised, list of all the cases included in this review, including the level of previous investigation and the level of scrutiny during this project.

3.2 REPORT AUDIT

3.2.1 An audit tool was developed for assessing the quality of the investigation and report. The tool was based on work led by Health and Social Care Advisory Service (HASCAS) previously carried out in the North West.

3.2.2 The audit tool contained standards which addressed how the incident was recorded, the way in which the investigation was conducted, the quality of the investigation and analysis described in the report, the actions identified and implemented, clarity over accountability and responsibility, and the structure and standard of the report. Finally, a recommendation was made to NHS North West regarding future steps. The complete tool is included in appendix three.

3.3 REVIEW PANEL

3.3.1 A review panel of independent expert clinicians was recruited by NHS North West. Their role was to scrutinise all the nineteen cases which had not received full independent investigation. None of the panel members had participated in any of the original internal investigations. They were completely independent of all mental health trusts in the North West and also independent of NHS North West. Review panel members consisted of two consultant psychiatrists, two senior mental health nurses, an experienced mental health social worker and a psychologist (appendix one).

3.3.2 All members of the review panel attended an induction day. In preparation they were provided with the audit tool and one case report which had been audited by Colin Dale's project team. They were briefed on the project, its remit and their role in the review process. A detailed discussion of the audit tool was followed by a number of revisions.

3.3.3 The main focus of the day was an in depth consideration of one case report which had already been audited. This gave the panel members an opportunity to work with the audit tool, challenge their judgements on the standards and further refine the tool.

3.4 AUDIT AND REVIEW OF INCIDENT AND INVESTIGATION REPORTS

3.4.1 Each review panel consisted of a psychiatrist, a mental health nurse and either the social worker or the psychologist, depending on the nature of the cases to be considered.

3.4.2 Review panels met eight times to examine the nine cases where a full independent investigation had not been carried out. The report(s) for each case were audited by the project team prior to the meeting. For each case the report(s), audit and timeline for the investigation process were sent to the review panel members in advance.

3.4.3 At the review panel meeting a detailed consideration of both audit and reports for each case was conducted. The trusts level of compliance against the audit standards and commentary were agreed. The summary of good practice points and areas for improvement was further discussed and agreed. All specific concerns or issues and any lessons to be learnt from the report were identified and noted. The project team amended the audit for each case and circulated it to each panel member to agree the final version. A maximum of three cases were reviewed at each meeting. Where possible, reports were grouped by trust so that trust wide themes could be identified.

3.4.4 It was unnecessary for the review panel to consider cases where a full independent investigation had already been completed. In these cases the project team audited each report and collated the conclusions and recommendations. There were twelve cases in total. One report had been used for the induction training so eleven were included for audit only. Items of good practice as well as recommendations for change and improvement for each case were included in a report for each Trust.

3.4.5 For each trust, a detailed summary was prepared bringing together any good practice points and recommendations for improvements in practice and service delivery for all cases. These organisation specific reports were discussed with each trust. There were no objections on the grounds of factual accuracy.

4. ROOT CAUSES, CONTRIBUTORY FACTORS -EMERGING THEMES

A detailed analysis of all the audits identified a number of key themes which were common to many of the cases. Appendix two shows which of these themes were identified in which cases. A description of the key themes and the number of times each occurred are outlined below.

4.1 CLINICAL PRACTICE (22 CASES)

4.1.1 This theme covered a wide range of events and issues likely to affect the quality of clinical practice. These include inadequate induction or training in the use of trust policies and procedures, such as prescribing of medications and information regarding bed management and availability.

4.1.2 Several Trusts had historically experienced difficulties in recruitment and retention of consultant psychiatrists and were reliant on the use of locum staff. This had resulted in problems with continuity of care. As a result, clinical supervision was not always available for junior or student clinical staff from nursing and medical backgrounds; they were unable to discuss the most complex aspects of their practice with a senior colleague.

4.1.3 Trusts were reliant on the professional codes of conduct to govern staff behaviour with regard to 'boundary setting' in professional relationships. There was therefore little or no guidance for staff that do not belong to one of the 'professional' groups.

4.1.4 There were some weaknesses identified in staff awareness of cultural issues, particularly in respect of the role of the extended family in ethnic minority groups.

4.2 APPLICATION OF THE CARE PROGRAMME APPROACH (19 CASES).

4.2.1 The key elements of this approach are the systematic assessment of an individual's health and social care needs. A care plan is developed to address those needs and a care coordinator appointed. There should be regular review and changes made to the plan to reflect changing need. Close working relationships between health and social services are required, as is the need to involve the service user and their carers.

4.2.2 In some cases, service user needs had not been adequately assessed, social circumstances or cultural needs taken into account. In others carer's needs had not been assessed and some carers had their own complex needs.

4.2.3 Arrangements for transfer or shared responsibility for care and treatment did not function adequately. This happened across all agencies between different services within a single agency such as acute mental health care and substance misuse services or between agencies such as primary care and specialist mental health care, and between specialist mental health care and A&E, social care or criminal justice agencies.

4.3 ENGAGEMENT WITH SERVICES (19 CASES)

4.3.1 In a number of cases, service users did not keep appointments for specialist mental health services or substance misuse services. Alternatively some attended appointments but did not follow plans for their care such as attendance at day hospital or at therapeutic activities. In some instances, services had closed a case when an appointment was not kept without sufficient attempts to encourage a service user to attend. For example, further appointment letters were sent without checking that the recipient had in fact received them or without attempting more creative approaches such as the use of text message reminders or visits from community services.

4.4 CLINICAL RISK ASSESSMENT AND MANAGEMENT (18 CASES)

4.4.1 This is a substantial component of the Care Programme Approach but occurred sufficiently frequently to warrant a separate category. There were examples when formal assessment of risk was not carried out systematically, or where risk assessment did not take into account factors such as:

- Domestic violence
- Criminal or violent behaviour
- Social stressors, for example when relatives had their own mental health or physical health care needs, bereavement or relationship breakdown

4.4.2 Other concerns included inadequate communication with criminal justice agencies and of recording risk factors. Several cases involved service users with long-term mental health needs and there was evidence that review of risk was not carried out for lengthy periods of time, with service users therefore receiving care and treatment not reflecting their current level of risk.

4.5 PROFESSIONAL/AGENCY COMMUNICATION (16 CASES)

4.5.1 There were a number of instances in which inter-professional or inter-agency communication was inadequate this included communication between acute mental health services and primary care, social care, specialist mental health care, criminal justice agencies and A&E departments.

4.6 MANAGEMENT OF SUBSTANCE MISUSE (15 CASES)

4.6.1 There were a wide range of issues around communication between mental health and substance misuse services, including voluntary sector providers. There was a lack of systems for active referral of service users from mental health to substance misuse services. There was evidence of a history of substance misuse not informing the risk assessment, evidence of not following Department of Health guidance for the management of drug misuse services and inadequate training for mental health professionals.

4.7 RECORD KEEPING (14 CASES)

4.7.1 In these cases, records had not been kept up to date, were not dated or signed, or were illegible. There was not always a formal, agreed record of meetings which had been held involving more than one agency or service. There were a number of cases where health care professionals could not access service user health records, particularly in other services such as A&E or in different geographical locations within a single Trust.

4.7.2 Where case records were lengthy, a summary of the key points of risk and other factors should be available at the front of the files; this was often not the case. This was particularly a feature where paper records were held in several or very large files, making access to relevant information difficult. This made it extremely difficult for professionals new to the treatment and care of an individual to identify key factors in a short time.

4.8 RESOURCES (11 CASES)

4.8.1 A high turnover of both medical and nursing staff had contributed to lapses in care and treatment of services users; where caseloads were high there was not always a system for prioritising those with the most urgent or complex needs. In some cases reconfiguration of services had been implemented without an assessment of the impact that this might have on the continuity of care for service users.

4.9 INVOLVING FAMILIES AND CARERS (9 CASES)

4.9.1 Some of the examples in this theme highlight the limitations of staff understanding of confidentiality and its application in clinical practice. In a number of cases health care professionals did not enable carers to express concerns regarding a service user, or did not appear to assess the significance of the information they were given. Opportunities were not taken to allow carers to speak to healthcare professionals without the service user being present, instead trying to talk to the relatives in the presence of the service user despite requests not to do so.

4.10 MANAGEMENT OF MEDICATION COMPLIANCE (8 CASES)

4.10.1 A key factor in these cases, whilst not being unique to mental health services, is non-compliance with prescribed medication which can be a serious problem, with dislike of unpleasant side effects and not feeling 'ill' being significant reasons for not taking medication. Features of these cases include services which were unable to monitor whether or not service users with a history of non-compliance with medication actually collected medication from the pharmacist.

4.10.2 In some instances medication dosage was reduced, at the service user's request, but without monitoring psychiatric symptoms. This included medication administration being changed from depot to oral preparations, where non-compliance was a known risk and without close monitoring and follow-up. In other cases when there was a history of non-compliance, service users were discharged from in-patient care without adequate follow up.

4.11 APPLICATION OF THE MENTAL HEALTH ACT (5 CASES)

4.11.1 In some cases there were indications that staff were not adequately trained in all aspects of the Act. Few services had opportunities for reflective learning for those primarily responsible for applying the Act. Full use was not made of all provisions of the Act and on occasions staff did not inform relatives of their rights under the Act to apply for detention.

4.11.2 Finally there were occasions where the behaviour of the service user was considered by the review panel to indicate that a formal assessment with a view to detention would have been appropriate. Professionals did not always consider detention of the service user to prevent further deterioration in metal health . This opportunity was not identified as such or taken up by the responsible professionals.

4.12 SAFEGUARDING CHILDREN (5 CASES)

4.12.1 There were cases involving children either as the victim or the perpetrator. Issues identified included failure to follow child protection procedures which were in place at the time. Concerns may have been expressed regarding a young service user but these were not always followed up. There were also cases where the children of parents with mental health needs were not assessed, despite them having some caring responsibilities. Finally, there were examples where the domestic circumstances were not fully assessed in terms of the risks from mental health service users within the home.

4.13 DUAL DIAGNOSIS (3 CASES)

4.13.1 Dual diagnosis refers to service users diagnosed with both a severe mental health issue and substance misuse. The key issues in this theme were the need to carry out regular reviews of people with dual diagnosis; and to ensure that a clear diagnosis is made as it can be difficult to distinguish between a psychosis triggered by drug use and a functional psychotic illness.

4. ROOT CAUSES, CONTRIBUTORY FACTORS -EMERGING THEMES

4.14 REVIEW PANEL CONCLUSIONS AND RECOMMENDATIONS

4.14.1 The project remit included both an analysis of the reports and recommendations for any further work.

4.14.2 The review panel reviewed all the case reports for incidents which had not been subject to a full, independent investigation and considered what further action should be taken. In each case, and after careful consideration, the panel concluded that it was not appropriate or necessary to commission further independent investigations, on the grounds that:

4.14.3 All cases had been subjected to further scrutiny by an expert panel and the root cause and contributory factors had been identified

- Sufficient information was already available on the cases to bring insightful learning for the services and that little extra would be gained by further full independent investigation.
- There has been a significant time-lag, in some cases eight years, since these incidents had occurred. Families and carers have moved on in their lives; organisations have changed and merged; personnel have moved on; potential witnesses are no longer available; clinical information may no longer be available; and service users had not given consent for an independent investigation panel to have access to their clinical records. In particular, the panels were concerned not to cause further distress to families of both victims and perpetrators by revisiting incidents that had taken place several years ago.
- The time, cost and service disruption from a series of independent investigations would be a significant demand on the services. The interests of the families, service users and the public would be better served by ensuring that the identified lessons were fully implemented in practice.

4.14.4 The review panel concluded that the more productive way forward would be to focus on gaining assurances that action had been taken in the light of the investigations that had been carried out, that lessons had been learnt and put into practice. Sharing learning across the North West would be beneficial to all services and to patient, carer and public safety.

4.14.5 The review panel therefore recommended that NHS North West should seek detailed assurances from each Trust that lessons had been learnt and that the organisations had either taken action to ensure that recommendations from the case reviews had been implemented or that there was a clear plan to do so.

4.14.6 NHS North West accepted this recommendation and agreed the next steps with trusts and review teams for gaining the necessary assurances from each trust. This would ensure that the recommended practice and service improvements had taken place and had been transferred into the new and merged trusts. The focus remained clearly on ensuring that lessons had been learnt and that the risk of similar situations recurring had been reduced.

PHASE TWO:

5. ASSURING IMPROVEMENT AND RISK REDUCTION

5.1 INTRODUCTION

5.1.1 In this second phase, the project moved from analysis to assisting NHS North West in seeking assurances that trusts had acted on the recommendations from the investigations and themed analysis or had clear and timetabled plans to do so. Supported by the review panels and the project team, NHS North West sought assurances from the trusts that changes had been made in practice and could provide evidence to support these assurances at the level of day-to-day practice and service delivery.

5.2 ASSURANCE PROCESS

5.2.1 The project team developed detailed recommendations based on all the review panel reviews and the recommendations from the independent investigations (appendix four`).

5.2.2 A meeting with representatives from of all the trusts was held in January 2009 to share the recommendations and to agree the process for them to provide the requisite assurances. It was agreed that each trust would be sent three reports: one with the recommendations from their individual cases, the second the recommendations arising from the key themes identified across the North West and the third an assessment of the quality of their investigation reports.

5.2.3 Trusts then submitted written assurances to NHS North West regarding their current position in relation to the recommendations and any action taken. The trusts were asked to provide evidence that the issues identified in the thematic review had been resolved and that the risk of a re-occurrence was significantly reduced. Trusts were asked to ensure that the evidence was robust with examples of operational compliance.

5.2.4 Following this submission formal feedback meetings were held between the project team, representatives of the trusts, PCTs and members of the Patient Safety Action Team at NHS North West. At these meetings Trusts were challenged on the robustness and strength of their evidence and breadth of their approach against the identified themes.

5.2.5 In the light of these discussions each trust submitted a revised document including additional evidence which were subject to further scrutiny and review. The project team and one representative of the NHS North West Patient Safety Action Team independently completed an evaluation of each trust response using the following criteria:

TABLE 1: CRITERIA FOR EVALUATING TRUST RESPONSES

CRITERIA
Recommendation was not specifically addressed or not adequately addressed
Relevant policy, guidance, established practice is described
Response includes reference to audit of policy/guidance/practice **which has been completed:**
Response includes evidence of action taken in response to audit findings **which has been completed**

5.2.6 The results were agreed along with a narrative record of key points. A report was then produced for each trust, providing an analysis and commentary identifying areas where further assurance was required. The trusts then finalised their assurance reports which are published as appendices five to twelve in this report.

5.3 ASSURANCE – TRUST RECOMMENDATIONS

5.3.1 Each Trust provided assurance that actions required in relation to the trust specific cases had been taken and the review team concluded that no further action was necessary.

5.3.2 All trusts reported that policies, procedures and standards of practice were in place in response to these recommendations. On occasion there was evidence that practical change had taken place and that trusts were monitoring compliance with those revised policies, procedures and standards of practice. All trusts demonstrated that they had continued to improve services in response to audit findings.

5.4 ASSURANCE – ALL RECOMMENDATIONS

5.4.1 This legacy case review has provided an opportunity to consider some of the current work activity in the eight mental health trusts in the North West. There was evidence of significant improvements in patient safety, in some cases leading edge practice as well as areas for further development. All trusts had responded to the recommendations common to the North West and this process has demonstrated the commitment of both the SHA and the mental health trusts in the North West to continual learning and improvement.

5.5 IMPROVEMENTS ACROSS THE NHS NORTH WEST

5.5.1 It was clear from the feedback meetings and evidence provided by the Trusts that major developments had taken place in the organisation and delivery of mental health services in the years since these homicides took place. These have resulted from the introduction of the National Framework for Mental Health and the NHS Plan. The evaluation of the final trust responses and assurances provided detailed evidence of progress and development. All trusts had made progress in addressing the recommendations arising from the key themes.

5.5.2 Trusts have identified improvements in their governance arrangements and the most frequent response to all the recommendations was that policies, procedures, guidelines, or standards of professional practice or service delivery had been developed and adopted across the trust. Trusts reported these developments in approximately three quarters of all recommendations. The trust assurance reports provide examples of improvements including:

- Development of assertive outreach teams, across the North West which enhances efforts to engage with service users, proactively support them to attend appointments and actively participate in care and treatment. Individualised strategies including telephone and text messaging reminders to service users of forthcoming appointments are also utilised to improve engagement
- Agreed information sharing protocols with a variety of relevant external agencies, including standards for transfer arrangements, and sharing care plans where appropriate. This includes involvement in the Multi-Agency Public Protection Arrangements, and Multi-Agency Risk Assessment Committees to enhance joint working with the criminal justice system.
- Dual diagnosis strategies with supporting procedures, including a link worker system to ensure communication and liaison between mental health and substance misuse services. Trusts reported that their strategies were based on current national guidance

5.5.3 Progress in monitoring compliance with policies and standards had been made across all trusts in respect of some themes. In particular trusts monitored compliance with the Care Programme Approach, for example:

- Annual audits of CPA policy implementation leading to action plans to rectify any deficiencies
- Regular board reports on the implementation of seven day follow up after discharge for service users subject to CPA: this follow-up focuses where necessary on issues of non-compliance with prescribed medication

5.5.4 Specific examples of trust approaches to ensuring compliance with policies, procedures, standards and guidelines relating to other themes include:

- Regular audits of record-keeping are in place to ensure standards are continually monitored
- Ward audits include questionnaire to staff regarding clinical supervision
- Training in the application of the Mental Health Act is subject to ongoing monitoring by the Mental Health Act administration team

5.5.5 Overall, trusts have made most progress in implementing recommendations related to the application of the Care Programme Approach. This theme had occurred nineteen times in the investigation reports so this represents evidence of improvement in a key risk area where improvement was required. However, there is scope for further improvement in relation to inter-professional and inter-agency communication.

5.6 EXAMPLES OF INNOVATIVE PRACTICE

5.6.1 Trusts reported a number of pieces of work which demonstrated exemplary, innovative and leading practice. These included activities which had been nationally recognised or involved internationally recognised experts. These include:

- Individualised strategies to improve compliance with medication, including motivational enhancement techniques, enlisting support of carers, information and discussion with service users, liaison between pharmacists and clinical teams, named pharmacist to dispense medications
- Partnership with a premier league football club to promote engagement of service users who have been difficult to engage in the past. This promotes social inclusion and participation, and aims to ensure
service users can relate positively to mental health care.
- Guidance to staff and teams on individual risk assessment and management and client care by forensic psychologist with internationally recognised expertise
- Scheme to provide children of parents with mental health problems with easily accessible information on whom to contact if they needed help (national pilot scheme).

5.7 AREAS FOR FURTHER DEVELOPMENT

5.7.1 A number of recommendations were identified as more challenging and trust responses indicated that regional support may be valuable to ensure that practice and management are more robust. In these instances, although trust responses did meet the criteria for demonstrating policies and procedures were in place it was considered that there was still some scope for improvement. It may be more effective for trusts to work across the North West on these areas to share the learning and address the issues. There are a number of networks of senior managers/professionals within the North West which could be the focus for this work.

- There were occasions when formal assessment under the Mental Health Act were not undertaken, despite circumstances indicating to the review panel that this could have been appropriate. Two Trusts have made progress in strengthening their governance and supervision arrangements and this learning could be made more widely available.

- Some trusts have robust systems and processes for ensuring that treatment complies with best practice; these systems could be usefully generalised across the remaining trusts. Services need to ensure that treatment follows from diagnosis: again some of the responses were weak whereas others made specific reference to use of NICE or other recommended guidelines.

- In relation to appropriate policies and training in boundary setting between healthcare staff and service users: some trusts seemed to rely primarily on professional bodies' codes of conduct rather than having their own explicit policies which applied to all staff, not just those who were members of professional bodies.

5.7.2 Additional themes which require further work include working with families and carers of service users; maintaining engagement of service users with services and mental health care professionals; clinical risk management; management of substance misuse; and management of non-compliance with medication.

6. CONCLUSIONS AND SUMMARY OF THE ASSURANCE FINDINGS

6.1 All trusts provided assurance that recommendations arising from their specific investigation reports had been addressed. In relation to the North West themes, all trusts reported that they had addressed all the themes in some degree although there were areas where responses could have been enhanced.

6.2 However, responses to the majority of recommendations from the thematic analysis made reference to implementing improvements in policies, procedures and standards of practice. In a proportion of these cases trusts also reported that they had implemented, or were planning to implement, audit and systems to monitor compliance with the revised policies, procedures and standards. Some trusts had made further progress and reported having an action plan or having taken action to implement change as a result of these audits. Several innovative practices and national initiatives were identified across the region.

6.3 Overall the exercise has enabled trusts to demonstrate progress in all areas identified through the thematic review, although there remain some areas where further development work or completion of work in progress is required. It has already been a valuable developmental process which has enabled trusts to engage in a focussed debate concerning patient safety. A number of examples of good practice have been identified through this process; including some where trusts in the North West are taking the lead in piloting national initiatives or have received recognition for aspects of work relevant to the homicide investigations reviewed for this report.

6.4 Where there is still room for improvement, in developing audit and monitoring compliance, or in taking action to improve services, commissioning PCTs will now be asked to take on responsibility for monitoring trusts continued improvements.

6.5 Overall, mental health trusts in the North West report greatly improved provision of mental health services, both in terms of professional practice, leadership and management and service delivery. These improvements may have reduced the likelihood of harm to service users, their carers and the public but cannot remove risk entirely. Consequently the commitment by NHS North West and the mental health trusts to continuous learning and improvement demonstrated through this project needs to be maintained.

APPENDIX ONE

APPENDIX TWO

APPENDIX THREE

APPENDIX FOUR

APPENDIX FIVE

APPENDIX SIX

APPENDIX SEVEN

APPENDIX EIGHT

APPENDIX NINE

APPENDIX TEN