An independent external quality assurance review following an internal investigation into the care and treatment of mental health service user J in South London

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

Our report has been written in line with the terms of reference as set out in the proposal for a quality assurance review following an internal investigation into the care and treatment of Mr J. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However, where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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1 Executive summary

1.1 South London and Maudsley NHS Foundation Trust (the Trust) provides a wide range of services in South London for people with mental health problems or an addiction to drugs and alcohol. The Trust provides inpatient, outpatient and psychiatric liaison services from a number of hospital sites.

1.2 J had been under the care of the Trust for five months prior to the incident. He was on agreed Mental Health Act (MHA) 1983 Section 17[1] leave prior to discharge from Clare Ward, Ladywell Unit, Lewisham Hospital. Clare Ward is a 17 bed mixed sex acute admissions ward.

1.3 On 8 July 2015 J utilised Section 17 leave at 9.30 am, attended his mother's address to apparently collect his flat keys and had agreed to return by 10:30 am.

1.4 However, feedback from the family indicates that his sister had previously given the keys to J's flat to the nursing staff on the ward for the purposes of an occupational therapy assessment visit, with a specific instruction to return the keys to the nursing staff and not to J. The sister managed to persuade J to return the keys to her, and subsequently the nursing staff, on her next visit.

1.5 J's mother called the London Ambulance Service (LAS) at 10.20 am requesting help. At 10.30 am she called Clare Ward expressing concerns about J's leave, however the 'phone cut off abruptly and staff were unable to reach her with a return call.

1.6 The LAS and the Police attended the scene. J's mother was found having suffered severe head trauma and in cardiac arrest.

1.7 At 11.50 am Clare Ward received a call from Lewisham Police stating that J had been arrested for a serious crime. At 1.15 pm the ward staff received a call from the Criminal Justice Mental Health Team informing them that his mother had died and his sister was critically ill in hospital.

1.8 J was arrested at the scene for grievous bodily harm against his mother and, following her death, for murder. No further formal information relating to action with regard to his sister is available for the purposes of this review, however J's brother informed us that he was charged with grievous bodily harm against his sister also.

1.9 He pleaded guilty to manslaughter on the grounds of diminished responsibility in March 2016. He was sentenced to an indefinite hospital order in April 2016. Specifically, the court outcome was a Hospital Order with a Restriction Order under Sections 37[2] and 41 of the MHA 1983 (as amended 2007) without time limit.

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1 https://www.legislation.gov.uk/ukpga/1983/20/section/17 Leave of absence may be granted by the Responsible Clinician to a patient under this section either indefinitely or on specified occasions or for any specified period; and where leave is so granted for a specified period, that period may be extended by further leave granted in the absence of the patient.

[2] *https://www.legislation.gov.uk/ukpga/1983/20/section/37 Where a person is convicted before the Crown Court of an offence punishable with imprisonment the court may by order authorise admission to and detention in hospital and the court may further order that the offender shall be subject to restrictions (section 41).*

1.10 The Trust conducted a serious incident internal investigation into the care and treatment of J in 2015. The internal investigation was commissioned by the Medical Director to carry out a comprehensive internal investigation in accordance with the NHS England Serious Incident Framework (March 2015).[3] The internal investigation also covered the terms of reference as specified by the Domestic Homicide Review (DHR) which was commissioned by the Safer Lewisham Partnership.

1.11 The internal investigation subsequently proceeded with a panel comprising a Consultant Psychiatrist, a Clinical Service Lead and a Trust Investigation Facilitator. The internal investigation was completed using root cause analysis methodology with the purpose of establishing any lessons that could be learnt in order to prevent future, similar incidents.

1.12 The internal investigation was commissioned 8 July 2015 and completed 15 February 2016. The report was approved by the Lewisham Clinical Commissioning Group 18 March 2016 and by the Trust Medical Director 6 September 2016.

1.13 This extended timescale was due to the Police not providing permission for the internal investigation team to commence staff interviews until 19 August 2015, or for the involvement of the family until 3 November 2015. The internal investigation team were advised by the Police Family Liaison Officer that the final report could not be shared with the family until the criminal justice process had concluded. The internal investigation team met with the family on 27 April 2016 and included their amendments in the final report, which was subsequently shared with the family on 22 November 2016.

1.14 The internal investigation found, from J's records, and all staff interviewed concurred, that J had a diagnosis of autism spectrum disorder (ASD) and that he experienced "an episode of adjustment disorder precipitated by difficulty in coping with stress at work (due to reduced staffing levels) in the context of a decreased tolerance of stress due to ASD".

1.15 The internal investigation found that the main issue was that there was no system or process to ensure that care plans were completed and reviewed in the ward rounds on Clare Ward, however this was not felt to have contributed to or caused the serious incident itself. The internal investigation found seven care and service delivery problems including:

- no care plan or associated documentation was complete;
- areas identified as a risk in the full assessment of 14 April 2015 were not care planned, explicitly acted or updated following significant events. A risk management plan was not written to address the areas raised in the risk assessment;
- there was no documented mental state assessment and risk was not explicitly considered by nursing staff prior to J going on leave on the morning of 8 July 2015;

[3] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf*

- the family felt that the concerns they expressed at the ward round of 7 July 2015 were not taken on board;

- the family did not receive a carers assessment;

- there was poor communication with the family; and

- although a referral had been made to the relevant service, local autism related expertise was not utilised.

1.16 The internal investigation made eight recommendations in respect of these findings (detailed in the assurance summary section of the report).

1.17 The Safer Lewisham Partnership followed the statutory guidance for DHRs (2013) issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. The DHR was completed in July 2015 and the Overview Report and Executive Summary published accordingly.

1.18 The DHR found that there were two routes, which, if taken, had the possibility of developing opportunities for the homicide to have been predicted or prevented. However, the DHR could not say definitively whether either could have prevented the homicide.

1.19 One route was through the identification of J's mother as a possible victim of domestic abuse and, or, as a vulnerable adult in need of safeguarding. The other route was through the thorough, comprehensive and holistic treatment if J's mental health condition, including a care plan that took account of his Autistic Spectrum Disorder[4] (ASD), physical and mental health.

1.20 The DHR made three single partner recommendation to the Trust:

- to review its response to domestic abuse, covering staff awareness and availability of training, the effectiveness and impact of policies and procedures, the identification of victims and perpetrators, risk identification and referral, and safe and appropriate ongoing work with those individuals including multi-agency working, and for a mechanism to be put in place for ingoing monitoring of the response;

- to report to the Safer Lewisham Partnership on the ways in which they have responded to the lessons learned about family concerns being acted upon during inpatient stays, and in particular in relation to risk assessment, planning for discharge and Section 17 leave; and

- to review the systems in place in adult mental health wards for maintaining dialogue with inpatient's GPs whilst they are on the ward. To feed back to the Safer Lewisham Partnership and to work with the (Lewisham) Clinical Commissioning Group (CCG) and NHS England as appropriate for taking any action needed to improve communication with GPs in Lewisham.

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4 https://www.icd10data.com/ICD10CM/Codes/F01-F99/F80-F89/F84-/F84.0 A disorder beginning in childhood. It is marked by the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interest. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual.

1.21 NHS England London commissioned Niche Health & Social Care Consulting (Niche) to undertake an external quality assurance review, specifically to:

- review Trust progress on the implementation of action plans developed from the internal and DHR reports;
- assess the robustness of the Trust and CCG governance processes in managing and monitoring the action plans. Specifically, the structures in place to ensure learning is embedded and whether changes have made a positive impact on the safety of Trust services; and
- highlight areas for further improvement derived from the above investigation, making recommendations for improvement as appropriate.

1.22 Niche is a specialist safety and governance organisation undertaking investigations into serious incidents in healthcare. Sue Denby, Practitioner, Governance and Investigations for Niche carried out the external quality assurance review, with expert advice provided by Kate Jury, Niche Partner for Governance and Assurance.

1.23 The investigation team will subsequently be referred to in the third person in the report. The report was peer reviewed by Dr Carol Rooney, Deputy Director, Niche.

1.24 The external quality assurance review has focused on the following key lines of enquiry:

- the implementation of the internal investigation and DHR recommendations;
- the impact of the action plan recommendations; and
- the governance and systems within the Trust.

1.25 The external quality assurance review commenced July 2018 and was completed April 2019.

1.26 We used the Niche Assurance Review Framework (NARF), to provide a well evidenced and rigorous assurance process.

1.27 In order to complete the review, we carried out a range of tasks including site visits, staff meetings, reviewing policies, procedures, minutes of meetings and various reports.

1.28 The terms of reference for this external quality assurance review are given in full at Appendix A. Staff interviewed are referenced at Appendix B. Documents and policies reviewed are referenced at Appendix C.

1.29 We have graded our findings using the following Niche criteria:

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

Summary of care and treatment for J

1.30 J was 44 years of age at the time of the homicide. He had worked for 15 years in a local, nationally known, chain store, and had lived alone in a Hexagon Housing property since May 2000.

1.31 J was under the care of the Trust Lewisham Assessment and Liaison Community Mental Health Team (CMHT) in December 2010 for a 'transient psychotic episode'. He had become very unsettled in his flat, saying he could see ghosts; he was hearing noises, taking out all the light bulbs and throwing his clothes away.

1.32 This episode resolved without any psychotropic medication. He received medication to aid sleep and a diagnosis of likely Asperger's syndrome[5]and was discharged back to the care of his GP in September 2011. The family were asked to look out for early warning signs of deterioration, and according to the information received from the Trust for the DHR, were provided with a crisis plan outlining contact with the GP, the CMHT, A&E or calling emergency services if necessary. However feedback from the family for the purposes of this review indicates that they did not receive a crisis plan.

1.33 J was referred to the Trust by his GP in May 2014 following concerns from his family. J had stopped taking his physical health medication, and was throwing his property away. The Trust assessment concluded that there were no signs of psychosis and he was discharged back to the care of his GP.

1.34 In February 2015, J was referred to the Trust by his GP after concerns from the family. Whilst the Trust were attempting to secure an assessment date with him, the GP undertook a home visit and found J lying and urinating in bed, not eating or drinking, and having stopped taking his physical heath medication. He was detained and admitted to Clare Ward on 27 March 2015 initially under Section 2[6] and later under Section 3[7]of the MHA 1983.

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5 https://www.icd10data.com/ICD10CM/Codes/F01-F99/F80-F89/F84-/F84.5 A childhood disorder predominately affecting boys and similar to autism (autistic disorder). It is characterized by severe, sustained, clinically significant impairment of social interaction, and restricted repetitive and stereotyped patterns of behaviour. In contrast to autism, there are no clinically significant delays in language or cognitive development.

6 https://www.rethink.org/living-with-mental-illness/mental-health-laws/mental-health-act-1983/sections-2-3-4-5 Under section 2, you can be kept in hospital for up to 28 days. This section gives doctors time to decide what type of mental disorder you have, if you need any treatment, and how treatment will affect your health.

7 https://www.rethink.org/living-with-mental-illness/mental-health-laws/mental-health-act-1983/sections-2-3-4-5 Under section 3, you can be detained in hospital for treatment for up to 6 months. You can be detained if you have a mental disorder, you are

1.35 On 14 April 2015 a referral was made to the Lewisham ASD service for advice and support. On 9 July 2015 the ASD service provided J with an appointment for 6 August 2015.

1.36 On 7 July 2015, following a ward round assessment, it was decided that J would be allowed a period of extended Section 17 leave to his own flat in order to assess how he would cope living on his own after discharge from the ward. It should be noted that J had been granted previous escorted Section 17 leave from the ward to the garden or park. Such leave was uneventful; leave was gradually increased and he became confident in going out alone.

1.37 The family were in attendance at the ward round and expressed concerns about the risk of his deterioration. They were reassured that he would be provided with support from the Occupational Therapist (OT). However, feedback from the family for the purposes of this review indicates that J did not receive support from the OT or was provided with a support package following discharge.

1.38 Later that day, J proceeded on Section 17 leave to spend the night in his flat, however he returned to the ward at 10.30 pm saying that he was not able to obtain the keys to his flat from his family, and his brother contacted the ward to say that J had been to his mother's house and smashed some CD's. This information was recorded but there was no plan for further action associated with this.

1.39 On 8 July 2015 J utilised Section 17 leave at 9.30 am, attended his mother's address to apparently to collect his flat keys, and agreed to return by 10.30 am. However, feedback from the family indicates that his sister had previously given the keys to J's flat to the nursing staff on the ward for the purposes of an occupational therapy assessment visit ,with a specific instruction to return the keys to the nursing staff and not to J. The sister persuaded J to return the keys to her, and subsequently the nursing staff, on her next visit.

1.40 J's mother called LAS at 10.20 am requesting help, and at 10.30 am she called Clare Ward expressing concern about the plan for extended leave and described the events of the day before with the CD's. However, the 'phone cut off abruptly and staff were unable to reach her with a return call.

1.41 LAS and the Police attended the scene. J's mother was found having suffered severe head trauma and in cardiac arrest.

1.42 At 11.50 am Clare Ward received a call from Lewisham Police stating that J had been arrested for a serious crime. At 1.15 pm the ward staff received a call from the Criminal Justice Mental Health Team informing them that J's sister was also critically ill in hospital and that his mother had died.

Structure of the report

1.43 Section 2 describes the process of the review and section 3 gives an overview of J's history and mental health treatment.

unwell enough to be in hospital, professionals think you should be in hospital for your own health or safety, or to protect other people, appropriate treatment is available for you, and you will not get this treatment unless you are detained.

1.44 Section 4 describes in detail the actions planned in response to the recommendations made by both the internal investigation and the DHR, and the progress the Trust has made in making and embedding change.

1.45 A summary is provided in section 5.

Assurance summary

1.46 It is acknowledged that this homicide has had far reaching effects on the Trust. Due to the major structural change within the Trust commencing in 2016 through to the present day, and as new services bed down, we found it difficult to assess the assurance against the original report actions very specifically, as structures and systems have changed considerably.

1.47 In summary, previously the Trust organisational structure at the time of the incident was built around Clinical Academic Groups (CAGs), which were formed in 2010 to bring together clinical and academic expertise to develop and deliver care pathways across the whole spectrum of mental health conditions.

1.48 A Crisis Assessment Team was launched in December 2017, operating a triage system covering all four Trust Boroughs. Referrals are received from the Police or LAS staff, supporting diversion at the triage stage. For context, in the first four months of its operation, 289 assessments were carried out by the team, 96 of which were resolved without the need to attend A&E and 41 of which avoided the need to be taken to a place of safety by the police (Section 136 MHA).

1.49 The Trust has undertaken a further restructure with services and operational management being aligned to Boroughs whilst the CAGs continue to focus on research, new care pathways and new models of care. This restructure was planned to create integration and coherence to services and included a redesign of community provision with the transition period running from April to October 2018.

1.50 The seven CAGs, led by Academic and Clinical Directors now focus on quality improvement, education and training, evidence and research to enable the development of new clinical pathways. The associated quality improvement programme monitors the acute care pathway and implement improvements across all Trust services.

1.51 The Trust new operational directorates, such as in the Lewisham Borough, where Clare Ward is situated, are led by a Service Director. Services are described as being Borough focussed with specific, quality focussed care pathways.

1.52 As part of the restructuring process in the Lewisham Borough, in addition to the Service Director there are new senior clinical posts. These include a Medical Lead, a Head of Nursing and Quality, a Modern Matron and a Governance Lead. We were informed, as a result of the restructuring process and these new posts, that governance, leadership and escalation have been improved.

1.53 However, we note the Care Quality Commission (CQC) Inspection Report

October 2018 stated that overall in the Trust the quality of leadership at a ward and team level was variable and was a key factor in whether the service was operating well.

1.54 The CQC stated that the Trust anticipated that the restructure of the operational directorates, resulting in smaller spans of control and increased levels of professional input, would deliver the support needed to make these improvements. We note that the Ward Manager on Clare Ward is newly appointed and has been in post since October 2018.

1.55 We have therefore assessed assurance as far as possible within Lewisham Borough, where applicable, and have provided further information about Trust assurance systems which have been put in place since then.

1.56 In terms of the eight Trust actions and three DHR recommendations we have summarised the Niche grading totals as follows:

Grade	Niche Criteria	Number
A	Evidence of completeness, embeddedness and impact.	1
B	Evidence of completeness and embeddedness.	4
C	Evidence of completeness.	3
D	Partially complete.	2
E	Not enough evidence to say complete.	1
	Total number of actions	11

1.57 Where the action resulted in a grading of B, C, D or E we have made residual recommendations for the Trust to seek formal assurance of the completeness, embeddedness and impact against each action as appropriate.

Residual recommendations

1.58 A summary of the recommendations can be found at para 1.81 and in full in the action plan progress section 4 of the report.

Trust action one

1.59 We found adequate assurance to grade this action as ‘A’ being completed, embedded and having an impact. No further recommendations are made.

Trust action two

1.60 We found adequate assurance to grade this action as ‘B’ being completed and embedded in practice.

1.61 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through compliments,

complaints or the National Inpatient Survey.

Trust action three

1.62 We found adequate assurance to meet this action and have therefore graded this as 'B' being completed and embedded in practice.

1.63 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through compliments, complaints or the National Inpatient Survey.

Trust action four

1.64 We found adequate assurance to meet this action and have therefore graded this as 'C' being completed. However, due to a Coroners Prevention of Future Death Report [8](PFD) and a further incident regarding Section 17 leave on Clare Ward, we have not been able to find adequate assurance, at this stage, that Section 17 leave practice is embedded. We expect that further audit and scrutiny through the Trust and Clare Ward level performance framework will provide this assurance in due course.

1.65 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area through the Trust serious incident action plan group. Feedback from the family for the purposes of this review suggests that information for carers should include Section 17 leave and we have therefore included this as a residual recommendation against Trust action seven.

Trust action five

1.66 Our view is that this action has been implemented, and we have graded this as 'C', however there is not enough assurance to indicate that supervision is embedded in practice.

1.67 We expect that further audit and scrutiny through the Trust and Clare Ward level performance framework will provide this assurance in due course.

1.68 We are satisfied that the impact of this action will be reviewed through the National Staff Survey and have no further recommendation to make in respect of this.

Trust action six

1.69 Specifically, in terms of risk assessment documentation and training, we

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[8]*https://www.judiciary.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths.pdf The Coroners concern is that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. It is concern of a risk to life caused by present or future circumstances. In the coroner's opinion, action should be taken to prevent those circumstances happening again or to reduce the risk of death created by them; the coroner has a duty to report the matter to a person or organisation who the coroner believes may have power to take such action.*

found adequate assurance to meet this action and have therefore graded this as ‘C’ being completed. However, given the recent learning from a serious incident and a PFD, we are not able to find adequate assurance at this stage that Section 17 leave practice is embedded.

1.70 We expect that further audit and scrutiny through the Trust and Clare Ward level performance framework will provide this assurance in due course.

1.71 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through the Trust serious incident action planning group.

1.72 In terms of supervision, we found that this action has been implemented, and we have graded this as ‘C’, however there is not enough assurance to indicate that supervision is embedded in practice. We are satisfied that this will be addressed through the Trust action plan in response to the CQC Inspection report October 2018 and the impact of this will be reviewed through the National Staff Survey results. We have no further recommendation to make.

Trust action seven

1.73 We have graded this action as ‘B’ having been implemented, and embedded in practice. However, feedback from the family for the purposes of this review suggests that information for carers should include Section 17 leave.

1.74 In terms of taking this forward and impact, we are satisfied that the Trust will address this through the processes for the delivery of the specific quality priority for 2018 -19 to routinely involve carers in the planning and delivery of their loved one’s care.

Trust action eight

1.75 We have graded this action as ‘D’ being partially implemented with the Consultant Nurse in Learning Disability appointed to deliver on the Greenlight Toolkit and the Learning Disability Improvement Standards, however given the CQC findings, we found that the action was not completed, embedded in practice or having an impact as yet.

1.76 We expect the Trust action plan against the CQC Inspection report October 2018 to ensure ward staff receive training in autism will address these issues. We have no further recommendations to make.

DHR recommendation nine

1.77 Although we could not source assurance of a specific review of the Trust response to domestic abuse, we found the Trust Policies on Safeguarding Adults and Domestic Abuse were comprehensive, and we found assurance regarding safeguarding training and recording of information through an audit cycle, monitored through the LSAB. We have therefore graded this action as ‘B’ being completed and embedded.

1.78 The Lewisham Adult Safeguarding Board (LSAB) discussed the headlines

from the document entitled 'Learning from DHRs' and the need for ensuring key themes and lessons to be learnt from domestic homicides and other reviews are captured for frontline staff. It was suggested that learning and service development seminars would be a way to do this by looking at different complex scenarios, and that a Case Review sub-group would ensure the LSAB is well sighted on all serious events ensuring that they are being scrutinised.

1.79 In terms of the impact of this action we are therefore satisfied that this will be addressed, through the LSAB. We have no further recommendation to make.

DHR recommendation ten

1.80 We could not find evidence that the Trust had reported as required and we have therefore graded this action as 'E' given that there is not enough evidence to say that this had been completed.

1.81 We recommend that this action is progressed to implementation, and the impact assessed, as required through the Trust Serious Incident Group Action Plan Assurance Meeting.

DHR recommendation eleven

1.82 We have graded this action as 'D' being partially complete because we found a lack of a specific review of the systems in place in adult mental health wards for maintaining dialogue with inpatients GPs whilst they are on the ward.

1.83 We recommend that the Trust uses the quality improvement initiative, called Icare, which has already been working with staff to standardise ways of working for inpatient services, to progress this action to full implementation as required, and to assess the impact of this.

Summary

1.84 The summary of the original internal investigation report and DHR recommendations, the Trust actions and the Niche gradings are as follows:

Number	Original Report Recommendation	Trust Action	Niche Grading
1	Psychosis Clinical Advisory Group (CAG) senior management to develop a process to review the length of stay when diagnosis is unclear to the local bed management system.	Bed management review system currently in place to ensure that all patients are considered by length of stay.	A
2	Clare Ward leadership team to conduct a full review of its internal electronic documentation auditing processes.	Clare Ward to audit expected documentation as laid out in acute care pathway admission protocol.	B

Number	Original Report Recommendation	Trust Action	Niche Grading
3	Clare Ward Manager and Consultant will ensure there are robust governance systems in place and risk assessments that address the plans made in the ward rounds	Ward rounds on Clare Ward to ensure that care plans have been completed and reviewed, including leave care plans.	B
4	Clare Ward to review policy and working practice regarding the conducting of risk assessments prior to a patient taking section 17 leave. This is to be audited after six months	Teaching session will be arranged on Clare Ward with the mental health act lead. Risk assessment documentation to be reviewed with the mental-health act office. Risk assessments to be documented in EPJS notes and if completed on paper to be uploaded within one working day and reference within the electronic record. Audit of completion for all patients detained under section to be completed on a weekly basis.	C
5	Clare ward to review the supervision processes on the ward and ensure that a review of named nurse clients are included in the process and supervision notes.	The ward will complete a review of supervision structures and provide evidence of structure following review. The ward will use a uniform supervision template for all ward staff including the ward manager. This template will include explicit expectation of named nurse interventions with their patients. Additional assurance will be provided by supervision to be audited monthly and presented to performance meeting with deputy director acute care pathway. Evidence of three-month cycle of audit presentation. Twelve-month review to demonstrate that this has been embedded.	C

Number	Original Report Recommendation	Trust Action	Niche Grading
6	The triage Ward Managers and Consultant to ensure there are systems in place to address any missing documentation to assure them that all patients have care plans risk assessments than address the plans made in ward rounds.	All risk assessments will be monitored through the inpatient dashboard. Clinical Service Lead to review and monitor dashboard for completion rates weekly. All qualified staff will have completed mandatory training on risk assessment. Band six nurse to complete monthly audit. Quality will be monitored through audit on each ward. Ward managers will ensure that risk assessment is a mandatory area for supervision. Ward Manager to ensure system for supervision is robustly followed external to the service area via Clinical Service Lead. Additional oversight will be provided by CAG governance forum on a monthly basis. Evidence of completion of three audit cycles required to show implementation and action taken. CAG to review in 12 months.	C
7	Clare Ward leadership team to develop information leaflets for patients families.	Clare Ward will develop information leaflets for patient families. This will embed provision for separate meetings for families and carers to be facilitated on all wards, where this is consistent with the patients capacity if permission is given, or best interests if capacity is lacking.	B
8	Trust-wide. Professional Leads for each CAG will enlist the help of experts in ASD to be considered when a patient with ASD is admitted to hospital. Pathways for obtaining this expertise to be clarified.	Green light tool kit actions to be put in place by Clinical Service Leads and Professional Leads.	D
DHR 9	The Trust to review its response to domestic abuse, covering staff awareness and availability of training, the effectiveness and impact of policies and procedures, the identification of victims and perpetrators, risk identification and referral, and safe and appropriate ongoing work with those individuals including multi-agency working, and for a mechanism to be put in place for ingoing monitoring of the response.	N/A	E

Number	Original Report Recommendation	Trust Action	Niche Grading
DHR 10	The Trust to report to the Safer Lewisham Partnership on the ways in which they have responded to the lessons learned about family concerns being acted upon during inpatient stays, and in particular in relation to risk assessment, planning for discharge and Section 17 leave.	N/A	B
DHR 11	The Trust to review the systems in place in adult mental health wards for maintaining dialogue with inpatients GPs whilst they are on the ward. To feed back to the Safer Lewisham Partnership and to work with the CCG and NHS England as appropriate for taking any action needed to improve communication with GPs in Lewisham.	N/A	D

2 Assurance review

Approach to the review

2.1 The external quality assurance review has focused on the action plan developed by the Trust following the completion of the internal investigation and the two multi-agency recommendations relevant to the Trust following the conclusion of the DHR.

2.2 We also reviewed the provision of Autistic Spectrum Disorder (ASD) services within the Trust.

2.3 The external quality assurance review commenced in July 2018, was completed in January 2019, and was carried out by:

- Sue Denby, Practitioner, Governance and Investigations.
- Kate Jury, Niche Partner for Governance and Assurance.

2.4 This external review was comprised of a review of documentary evidence supplied and interviews with key clinicians and senior staff from the Trust.

2.5 We have graded our findings using the following criteria:

Grade	Niche Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.

E	Not enough evidence to say complete.

2.6 As part of our review we interviewed:

- Associate Director of Quality NHS Lewisham Clinical Commissioning Group.
- Consultant Clare Ward.
- Ward Manager Clare Ward.
- Lewisham Modern Matron.
- Lewisham Head of Nursing.
- Head of Patient Safety.
- Deputy Director of Nursing and Quality.
- Consultant Nurse Learning Disability.

2.7 The terms of reference for this external quality assurance review are given in full at Appendix A. Staff interviewed are referenced at Appendix B. Documents and policies reviewed are referenced at Appendix C.

2.8 The draft report was shared with NHS England, the Trust and NHS Lewisham CCG. This provided opportunities for those organisations that contributed significant pieces of information to review and comment upon the contents.

2.9 Please note that on 1 April 2020, NHS Lewisham CCG merged with the five other CCGs in south east London to become part of NHS South East London Clinical Commissioning Group.

3 Summary of care and treatment for J

Date	Service	Summary of involvement
December 2010 to September 2011	SLAM	J experienced a 'transient psychotic episode' which resolved without any psychotropic medication. He received medication to aid sleep, a diagnosis of likely Asperger's syndrome and was discharged back to the care of his GP.
May 2014	SLAM	J was referred by his GP following concerns from his family. There were no signs of psychosis and he was discharged back to the care of his GP.
19 March	SLAM	J was assessed at his mother's house following a one week history of having collapsed due to stress at work. He lay urinating in bed, refusing to eat, drink or take his physical health medication. He was detained and admitted to Clare Ward under Section 2 and later under Section 3 of the Mental Health Act 1983. It took some weeks of encouragement from staff before it was agreed that J could leave the ward to go on escorted leave to the garden or park. Such leave was uneventful, and reported that he had enjoyed it. His leave was gradually increased and he became confident in going out alone.
7 July 2015	SLAM	Following a ward round review, it was decided that J would be allowed a period of extended Section 17 leave to his own flat in order to assess how he would cope living in his own after discharge from the ward. Feedback from the family for the purposes of this review indicates that the family were not informed about what Section 17 leave involved.
7 July 2015	SLAM	J proceeded on Section 17 leave to spend the night in his flat, however he returned to the ward at 10.30 pm saying that he was not able to obtain the keys to his flat from his family. His brother contacted the ward to say that J had been to his mother's house and smashed some CD's. This information was recorded but there was no plan for further action..
8 July 2015	SLAM	J utilised section 17 leave at 9.30 am, attended his mother's address to apparently collect his flat keys, and agreed to return by 10.30 am. However, feedback from the family indicates that his sister had previously given the keys to J's flat to the nursing staff on the ward for the purposes of an occupational therapy

Date	Service	Summary of involvement
		assessment visit ,with a specific instruction to return the keys to the nursing staff and not to J. The sister persuaded J to return the keys to her, and subsequently the nursing staff, on her next visit. J's mother called the LAS at 10.20 am requesting help, and at 10.30 am she called Clare Ward expressing concern about the plan for extended leave and described the events of the day before with the CD's. However, the 'phone cut off abruptly and staff were unable to reach her with a return call.
8 July 2015	SLAM	At 11.50 am Clare Ward received a call from Lewisham police stating that J had been arrested for a serious crime. At 1.15 pm the ward staff received a call from the Criminal Justice Mental Health Team informing them that J's sister was critically ill in hospital and that his mother had died.

4 Action plan progress

Governance and learning

4.1 We reviewed the governance structures and processes for managing internal investigation and DHR action plans by speaking to the NHS Lewisham CCG Associate Director of Quality, the Trust Patient Safety Lead and Deputy Director of Nursing and Quality. We viewed the CCG and Trust serious incident panel meeting terms of reference, minutes, quality assurance checklist and themed learning reports.

4.2 We were informed that at the time of the incident in 2015 the CCG was just at the cusp of changing the system for the oversight and monitoring of internal investigation reports. Reports were being signed off jointly between the CCG and the Commissioning Support Unit (CSU). This process was brought 'in house' to the CCG who then employed an external reviewer to review the internal investigation and feed back to the Trust.

4.3 With regards to this incident in 2015 the CCG received a copy of the initial 24 hour Strategic Executive Information System (StEIS) report for this incident, however could not confirm whether they had received a subsequent 72 hour report. Subsequently, the CCG received the completed internal investigation and it was 'signed off' as a good and thorough investigation.

4.4 A CCG serious incident panel meeting was then convened in June 2017, chaired by a GP with an interest in mental health, to gather the assurance against the internal investigation actions. However, the meeting was deferred to August 2017 due to the DHR process, to ensure that any additional actions were included. The internal investigation report and actions were then closed.

4.5 We were informed by the CCG that since then the serious incident oversight

and monitoring system has changed and at present it is not working quite as effectively. The changes to the system have been driven by the Trust as they had four Borough contracts and four different serious incident panels each operating slightly differently.

4.6 The Trust wanted to improve the way they 'signed off' and learnt from serious incident investigations internally. As a result, the Trust set up a monthly internal serious incident panel chaired by the Director of Nursing, and invited representation from the four Borough directorates and CCGs. This system is now mirrored in each directorate chaired by the local Medical Lead.

4.7 The first monthly meeting of this nature was in December 2017. The agenda is divided up so that each Trust Borough Service Director attends and presents the relevant Borough internal investigation report. A joint agreement between the Trust and the relevant CCG is then made to close the internal investigation report at the appropriate time. We were informed by the CCG that the quality of the internal investigation reports is improving.

4.8 When this new system started, the agenda for the serious incident panel included presentations of newly completed internal investigations and actions from previous investigations, however this made the agenda too long and complicated. So now only presentations of newly completed internal investigations are discussed at this meeting, using a quality assurance checklist.

4.9 The Trust told us that the internal serious incident panel provides the opportunity for challenge, discussion and debate about the report with the commissioners present. The Trust are open to feedback prior to approval and some reports do require changes to be made or there may be further questions that need addressing.

4.10 A separate Trust serious incident action plan assurance meeting, with CCG representation, was set up in autumn 2018 to sign off the action plans. Terms of reference or a standard operating procedure have not been developed for this meeting as yet.

4.11 Actions are recorded on the Trust electronic serious incident system (DATIX) which has an automatic function to indicate when actions are due, however the system is not able to indicate the quality of the actions. For comprehensive investigations, there is now an allocated Executive Director Lead responsible for the action plan assurance, checking that it is appropriate, fit for purpose and requesting more evidence where required.

4.12 In terms of any concerns about timeliness or quality of the internal investigation report this is raised at a CCG and Trust monthly contracts information meeting, and this information is communicated weekly to the services with Director of Nursing oversight. Extensions to the internal investigation completion date may be granted with a clear rationale. For every CCG and Trust directorate there is a report which tracks timeliness and action status.

4.13 In terms of the CCG structures and processes for holding the Trust to

account, we were informed that the Trust serious incident panel meeting allows for discussion and requests for further information. If the request for further information was not forthcoming, the CCG would write to the Trust Chief Operating Officer to resolve the issue.

4.14 The CCG Clinical Quality Review Group (CQRG) is also a vehicle for holding the Trust to account; they have held a discussion about the new serious incident process, their concerns and the processes the CQRG would like to see in place. The CCG will request a 'deep dive' in a couple of months' time to assess progress.

4.15 In terms of learning across the Trust, the CCG told us that the new serious incident panel arrangements assists with this, however learning across such a large Trust is quite complex, and they do not have a learning lessons document, framework or policy.

4.16 The Trust utilises a system for learning called 'blue light bulletins' which capture immediate learning and serious incident learning lessons reports.

4.17 Themed learning reports are submitted to the CQRG quarterly and to the Trust Board. We were informed that this report has improved over the years and is now a better thematic analysis.

4.18 We viewed a January 2019 Trust Board paper presented as part of the changes to improve oversight of serious incidents. The report stated that the aim of the paper was to provide the Board with oversight and assurance that recommendations from serious incidents are being implemented to reduce potential future harm. Additionally, to ensure that lessons learned are disseminated within the appropriate directorate and where appropriate there has been Trust wide learning.

4.19 This particular paper was a presentation of an incident, providing assurance to the Board that the incident had been thoroughly investigated together with delivery of the recommendations. We found a very detailed report with learning actions, oversight and assurance.

4.20 We viewed the January 2019 Learning from Deaths (quarter two) Trust Board report which provided an update on the Mortality Review Process in the Trust, the identified learning and challenges to the process.

4.21 Specifically, the Mortality Review Group reviewed the available data using each directorate's mortality reviews for quarter two in December 2018 and identified themes across services. Learning for each of the themes identified was stated as being addressed through current Trust processes overseen by the Trust Executive.

4.22 In terms of relevance to this incident, a key relevant learning point identified was the quality and completion of care plans and risk assessment. The report stated that as with previous quarter's reviews, the quality of risk assessments and care plans was found to be variable with areas of improvement in the current stage of details on the service user's current situation and changes in their physical health.

4.23 The directorates were stated as monitoring the compliance and quality of

risk assessments through audits reviewed in governance executive meetings. This information then feeds into joint Trust Director of Nursing and Chief Operating Officer chaired performance and quality meetings to be reviewed with the relevant learning to ensure improvements are made.

4.24 A further key relevant learning point, relevant to this incident, was identified as being interagency communication, with evidence of some excellent liaison with other services including internally with CMHTs and externally with GPs, translated into individual care plans.

4.25 In terms of overarching learning, the Trust told us that there are team leader events that take place quarterly, directorate events, and the 'blue light bulletins'. The internal serious incident panel communicates key themes through reports taken to teams for discussion and to the directorate serious incident panels. With this incident we were told that the learning was shared right across the inpatient pathway which was the clinical operational structure at the time.

4.26 Consideration is now being given to how to share learning across the Trust given there is a Borough operational structure which makes it a bit more complex. There are plans to look at how the internal serious incident panel can share information more widely.

4.27 Additionally, we were informed that following an external review of serious incidents, Trust workshops are currently taking place, looking at how combined bespoke learning from serious incident reports can be delivered. The external review also looked at the quality of the serious incident reports to see how recommendations and actions are formed and how these can be improved. We were told that these workshops were well attended across the directorates.

4.28 Staff in Lewisham and on Clare Ward told us that structures for embedding learning include a member of staff attending the local quality meeting which feeds into the business meeting. The local quality governance lead delivers on circulating anonymised learning within the directorate, systematic thematic analysis for discussion in local serious incident panels and identifying repeat incidents with different patients, which they try to quickly respond to. The 'blue light bulletin' is taken to the business meetings and left in the ward office for staff to read.

4.29 In summary, we found the Trust structures for learning to be satisfactory, and that they are developing a robust serious incident system with new processes for monitoring the timeliness and quality of internal investigation reports and the monitoring of action plans, working closely with the commissioners in each of the Boroughs. We are satisfied that the CQRG will provide the oversight to this development. Our view is that it may be helpful for the Trust to have a learning lessons document, framework or policy.

4.30 However, we found that the three single agency DHR recommendations for the Trust were not included in the internal investigation action plan.

4.31 We were informed that the governance structures and processes for managing internal investigation and DHR action plans were different at the

time of the incident, in that there were separate lead staff members for serious incidents and safeguarding (including DHR's).

4.32 We were informed that the Deputy Director of Nursing and Quality holds a single management line for safeguarding and serious incidents and we found this to be a positive development. We were informed that the Deputy Director of Nursing and Quality is to hold a joint meeting between the serious incident and safeguarding leads.

4.33 It is expected that this will improve lines of communication and integration of serious incident and safeguarding processes, with safeguarding leads working closely with the Local Authorities ensuring that safeguarding and DHR processes are linked up within the Trust, and recommendations communicated and agreed.

4.34 Given the DHR reported later that the Trust internal investigation, we were reassured that DHR actions are now recorded in the action plans for internal investigations (or added into those which have already been completed as an addendum) and would be monitored in the Trust serious incident action planning meetings.

Trust Action one

Number	Original Report Recommendation	Trust Action	Niche Grading
1	Psychosis CAG senior management to develop a process to review the length of stay when diagnosis is unclear to the local bed management system.	Bed management review system currently in place to ensure that all patients are considered by length of stay.	A

4.35 To review whether there is a bed management review system currently in place to ensure that all patients are considered by length of stay, we spoke with staff and reviewed relevant Trust service and operational structures, assurance systems and CQC Inspection Reports.

4.36 We note that the Psychosis CAG is no longer in operation in the way it was at the time of the incident, as, the Trust has been undertaking a restructure with services and operational management being aligned to Boroughs whilst the previous structure of Trust wide Clinical Academic Groups (CAGs) focus on research, new care pathways and new models of care including the redesign of community provision.

4.37 We note the Trust two year plan dated 13 December 2016 entitled 'Developing Acute Inpatient Services; Lessons from Triage' in which information is provided on the number of beds the Trust was commissioned to provide at the time together with the demand and occupancy rates. It provided background detail on the operational service and systems in place to manage the patient flow.

4.38 It stated the Trust aims as being to minimise out of area admissions, eliminate external bed overspill, minimise delays to discharge and reduce the average length of stay. The document provided an overview of the Trust two year plans to achieve these aims by developing an Acute Referral Centre (ARC), a bed management system with data led decisions, new

Modern Matron posts, a standardised multidisciplinary team and a quality improvement agenda.

4.39 We note the Trust Annual Report 2017-2018 stated that during the year, the main drivers of the Trust's performance were the impact of high levels of adult acute inpatient activity resulting in the use of beds outside the Trust. While rates of admission were stable or reduced, the anticipated reductions in length of stay did not materialise as planned.

4.40 We note that since 2016, assurance has been provided by the CQC Inspection Report October 2018 which stated that the Trust had systems in place to identify risk, that the Board assurance framework had recognised the pressures on the acute care pathway and a system was in place to identify the performance of wards and teams using a range of indicators.

4.41 However, the CQC stated that there was a 'disconnect' between these systems and the front-line services. At the time of the inspection, bed occupancy was above 100 percent on most of the acute wards with patients placed out of the area due to a lack of beds being available, a bed was not always available for patients returning from leave and some patient discharges were delayed.

4.42 The Trust stated that in 2018-2019, there will be a continued focus on reducing reliance on external beds and driving lengths of stay down so that they can achieve about 85 percent occupancy. We note the Trust Board report January 2019 states that the average Trust length of stay over the past 21 months is 50 days (against a target of 35 days) for all Borough based adult inpatient wards.

4.43 To deliver on length of stay targets and other key metrics for inpatient wards the Trust has implemented a system called the flow plan. All key controls are included in the patient flow plan which has 23 separate projects, each with progress plans at a Borough level. The flow plan is assured at a weekly meeting, chaired by the Chief Executive, where Boroughs have to produce evidence of progress against the plans.

4.44 As a result, the Trust has developed the ARC service and an associated Policy entitled ARC and the Management of Patient Flow (ratified 1 May 2018, review July 2019) which states that the ARC operates as a single point of access for the acute pathway with Home Treatment Team (HTT) triage alongside a bed admission function.

4.45 The ARC works with an ethos that discharge begins at the point of admission and HTT triage staff provide an estimated discharge date for the patient as a clinically estimate of the likely length of stay. If there is any doubt, a 28 day default position is taken. The ARC electronic dashboard is used collectively by ARC, HTT and the wards to monitor bed occupancy, planned movements, overspill, and delayed discharges.

4.46 The Trust already had a HTT in place and an associated Policy (ratified 26 May 2017, review September 2017) linked to the ARC through the triage function which includes processing referrals to HTT. One of the functions of the HTT is stated as being to facilitate early discharge of people receiving

inpatient treatment, therefore impacting positively on length of stay.

4.47 To support the approach to bed management and reduced length of stay, there have been NHS Improvement Multiagency Discharge Events (MADE) held Trust wide, looking specifically at 30 day length of stay barriers with data from 50 patients, bringing together the local health system to support improved patient flow across the system, recognise and unblock delays, challenge, improve and simplify complex discharge processes.

4.48 These are now being held at Borough level as mini MADEs with the Medical Leads working closely with the HTT's to improve the patient flow. Staff told us that these events show that discharges are facilitated when the patient is ready to leave hospital, and that staff feel supported in the process.

4.49 Overall, the Trust has now completed two rounds of MADE events in each Borough, holding 16 workshops which have reviewed over 400 patient cases, and a Trust-wide review of the first round has been completed. A full review of the second round of events will be completed on 8 March 2019.

4.50 MADE brings together internal and external partners and focussed on the most challenging discharges and has successfully reduced the Trust over 50-day length of stay cohort from 196 to 165 patients, and the over 100-day length of stay cohort from 103 to 76 patients. However, the over 100-day length of stay cohort are staying much longer.

4.51 MADE is now being embedded in Boroughs as part of normal bed management business and the next Trust-wide step is an individual review of all the over 100-day length of stay cohort patients to understand how their particular needs can be met, which may include commissioning different models of care and work has begun with the South London Partnership (SLP) to develop specialist placement portfolios.

4.52 As part of these bed management developments, the Trust uses a system called 'Red to Green' to improve patient flow by minimising barriers to discharge. They identify barriers as soon after admission and work with the ethos that every day counts. 'Red to Green' is now rolled out across all adult wards in the Trust and will be embedded into normal business by the end of March 2019.

4.53 'Red to Green' is a system developed in general medicine and adapted for mental health services. It is a tool to aid daily multidisciplinary team decision making to ensure that every day spent in hospital is meaningful and contributing to a person's recovery. It also helps teams to identify common barriers to discharge and empowers them to refine their ward processes or promptly escalate issues that they need help to resolve.

4.54 The system addresses other issues including tasks required (staff are allocated specific tasks), and a snapshot of what needs to be done for a patient every day, thus also providing an audit trail. The system improves the patient experience by contacting key people involved and providing support, for example, with their benefits.

4.55 We found that staff view systemic over occupancy and bed pressure as not being conducive to working with people in a meaningful and considered

way. If there are no beds, then capacity is sought from the independent sector which is thought to be much better for patients and carers.

4.56 Additionally, staff told us that where there is an unclear diagnosis, there are options to refer to other teams who provide an opinion. If there is a need, the opinion can be escalated and discussed further if necessary to the Medical Lead. Staff provided a working example to illustrate how this works in day to day practice.

4.57 In summary, we found that the Trust has comprehensive systems in place to address bed management and length of stay.

4.58 The Trust Annual Report 2017-18 reflects a downward trend in admissions and length of stay, stating that patients with longer lengths of stay are reviewed weekly at clinical meetings and regular interface meetings between community services and inpatient wards take place with a particular focus on strengthening the joint working and awareness between community teams and wards.

4.59 We note the Trust Board assurance framework 2017- 2018 details strategic change and innovation as a mitigated risk area with performance monitoring of key performance areas including length of stay and other throughput and quality measures such as patient experience as sources of assurance.

4.60 We therefore found adequate assurance to meet this action and have therefore graded this as 'A' being completed, embedded and having an impact. No further recommendations are made.

Trust Action two

Number	Original Report Recommendation	Trust Action	Niche Grading
2	Clare Ward leadership team to conduct a full review of its internal electronic documentation auditing processes.	Clare Ward to audit expected documentation as laid out in acute care pathway admission protocol.	B

4.61 To review whether there has been an audit of the acute care pathway documentation we spoke to staff, examined the acute care pathway summary document, Trust electronic care record systems, performance management systems and key performance indicators, and Clare Ward admission, transfer, discharge and Section 17 leave documentation.

4.62 In terms of the internal electronic systems, the Trust has had an electronic patient journey system (EPJS) and one clinical record system in place since 2006. From March 2018, the Trust joined up two electronic care record systems used by health and care organisations. This means that health and care staff have better access to more accurate information across the organisations. We note that the Trust Annual Report 2017- 2018 states that they have also moved to using a new digital system which enables staff to access up to date information, even when not on site.

4.63 The Trust was awarded Global Digital Exemplar (GDE) status by NHS England and received funding over three years to help ensure care is more

personalised and responsive to patient needs and to support the digital transformation of services. This includes projects such as electronic observations, electronic prescribing, improvements to the electronic record and the development of a new online Personal Health Record (PHR).

4.64 In terms of care pathway audit, the Trust has an electronic Performance Management Framework for the operational directorates with key performance indicators across workforce, activity and quality. As part of this, the Trust Board receives an associated performance dashboard each month, as well as a quality dashboard. Performance and quality indicators are used at the monthly operations meetings, and include performance and progress against the quality targets and priorities.

4.65 Teams are now working to pro forma templates which set out what data they should be looking at, and what they should be discussing at their team meetings; this format is replicated at all levels and feeds up to the overarching Performance and Quality report.

4.66 In specific terms of the acute care pathway, the Trust key performance indicators include HTT admission gatekeeping, whether a full risk screen was undertaken, occupied bed days, delayed discharges, seven day follow up after discharge and whether a Care Programme Approach[9] (CPA) 12 month review was undertaken.

4.67 We found a comprehensive acute care pathway summary document detailing tasks from admission to discharge. We found an acute care pathway electronic dashboard clearly indicated, down to individual patient level, whether they had received a risk screen, a child risk screen, and a care plan (including a physical health care plan and nutrition screen).

4.68 We viewed the specific Clare Ward admission, transfer, discharge and Section 17 leave documentation developed as part of the review process for the acute care pathway. The admission checklist contains actions to be completed immediately, within the first four and then at 72 hours. The discharge and transfer checklists contains lists of actions to be completed.

4.69 We spoke to several members of the multidisciplinary team on Clare Ward and found that the admission, discharge, transfer Section 17 leave and risk assessment prior to leave processes were understood and able to be articulated.

4.70 We were informed that new admissions are reviewed in the ward round on the first day and the risk assessment pulls through automatically to formulate a multidisciplinary care plan created via the use of a live screen of the electronic data system. Section 17 leave care plans are authorised by the Consultant Psychiatrist in this setting and daily reviews take place thereafter.

4.71 We noted the associated systems called ‘Red to Green’ to improve patient flow by minimising barriers to discharge outlined in relation to original report

[9] https://www.rethink.org/diagnosis-treatment/treatment-and-support/cpa *The Care Programme Approach (CPA) is a package of care that may be used to plan mental health care. Under CPA you are allocated a care coordinator who monitors care and support.*

recommendation and Trust action number 1 (see 4.52 - 4.53). These actions are recorded electronically.

4.72 We viewed a leave from the ward risk assessment document which recorded the time the patient left the ward, the time the patient was expected to return, what the patient was wearing and focussed risk assessment details.

4.73 We viewed a Section 17 leave paper template which contains a risk checklist held in a ward folder which all staff are shown how to use (including bank staff). We were informed that the ward administrative staff uploads the Section 17 leave forms electronically and the expectation is that this task will be completed daily.

4.74 Staff told us they check that the Section 17 leave form is authorised by the Consultant Psychiatrist and with the Nurse in Charge, and a further risk assessment is undertaken and recorded before the patient leaves. Section 17 leave can be cancelled by any member of the staff if risk assessed has increased for any reason.

4.75 We therefore found adequate assurance that the Trust has reviewed the documentation associated with the acute care pathway and has audit systems in place. We have therefore graded this as 'B' being completed and embedded in practice.

4.76 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through compliments, complaints or the National Inpatient Survey.

Trust Action three

Number	Original Report Recommendation	Trust Action	Niche Grading
3	Clare Ward Manager and Consultant will ensure there are robust governance systems in place and risk assessments that address the plans made in the ward rounds	Ward rounds on Clare Ward to ensure that care plans have been completed and reviewed, including leave care plans.	B

4.77 To review this action, we spoke to staff, examined the acute care pathway summary document, Trust electronic care record systems, performance management systems and key performance indicators and referred to our findings for Trust action two (4.70 – 4.74).

4.78 Additionally, we note that in Lewisham, the CQC Inspection Report October 2018 found that information gathered from the risk assessment and the person's previous contact with mental health services was used to produce care plans to help support and manage the person's mental health.

4.79 We note further assurance from the Trust Board report January 2019 which states that there has been an improvement since October 2017 in the number of care plans devised collaboratively with service users and shared with them.

4.80 We viewed care plan audits and a 'snapshot' of the electronic care record for Clare Ward which indicated that of 23 patients 22 had a care plan at the time.

4.81 We therefore found adequate assurance to meet this action and have therefore graded this as 'B' being completed and embedded in practice.

4.82 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through compliments, complaints or the National Inpatient Survey.

Trust Action four

Number	Original Report Recommendation	Trust Action	Niche Grading
4	Clare Ward to review policy and working practice regarding the conducting of risk assessments prior to a patient taking section 17 leave. This is to be audited after six months	A teaching session will be arranged on Clare Ward with the mental health act lead. Risk assessment documentation to be reviewed with the mental-health act office. Risk assessments to be documented in EPJS notes and if completed on paper to be uploaded within one working day and reference within the electronic record. Audit of completion for all patients detained under a MHA section to be completed on a weekly basis.	C

4.83 To assess whether a teaching session took place and whether risk assessment documentation was reviewed, documented and audited, we spoke to staff, reviewed Clare Ward risk assessment audits and the Trust approach to clinical risk, the CQC Inspection Report October 2018 and ensuing Trust actions.

4.84 The Trust Annual Report 2017-2018 states that managing clinical risk is central to all the work that the Trust undertakes and that to manage risk all clinical staff receive clinical risk management training commensurate with their grade and experience. Clinical risk training was included as a Trust mandatory training requirement in 2015.

4.85 In terms of clinical risk training, the Trust uses a learning management system called LEAP which is fed by the Electronic Staff Record (ESR; the Trust's HR and Payroll system) which provides detailed information on individuals and the characteristics of their job role, which in turn dictates the mandatory training they are required to do. We note that throughout 2018, Trust mandatory compliance levels in December 2018 were met at 85 percent.

4.86 The Trust Annual Report details quality improvement work that has been undertaken as a result of the CQC 2015 and 2017 inspections including a new risk assessment audit tool which has been disseminated across the teams with guidance; used as a learning tool within staff supervision.

4.87 The CQC Inspection Report October 2018 stated that staff used the new risk template, which prompted them to complete these records in detail. Staff completed and updated risk assessments for each patient when

necessary and used these to understand and manage risks individually.

4.88 We took assurance from the CQC Inspection Report October 2018 which found improvements in the quality of risk assessments and risk management plans in several services. The report stated that ward teams generally assessed and managed patient risks well, that staff mostly completed patients' risk assessments without delay, that risk assessments were comprehensive, up to date and had associated risk management plans in place. Staff reviewed patient risk at multidisciplinary team meetings each day.

4.89 Specifically, in Lewisham, the CQC found that a full risk assessment was undertaken to identify any concerns regarding the person's behaviour and whether there was a risk that they may cause harm to themselves or others. The information gathered from the risk assessment and the person's previous contact with mental health services was used to produce care plans to help support and manage the person's mental health.

4.90 We did not find assurance that a specific teaching session regarding the MHA took place on Clare Ward, however, we note the CQC Inspection Report 2018 stated that staff understood their roles and responsibilities under the MHA 1983 and the Mental Capacity Act[10] (MCA) 2005. They had received appropriate training and knew how to support patients, including those who lacked the capacity, to make decisions about their care.

4.91 We note the electronic care record system allows examination of risk assessments, care planning activities and MHA status at patient level and viewed a snapshot of the system showing the majority of risk assessments had been completed at the time.

4.92 We reviewed Clare Ward monthly care plan audits October 2017 to August 2018 which examined whether a risk assessment had been completed prior to completing a care plan. For April, May, June and August 2017 the results were 100 percent. The audits also examined whether each identified area of risk had an associated care plan. For June, July and August 2018 the results were 100, 22 and 71 percent respectively.

4.93 As an example of audit of risk assessment prior to Section 17 leave, we examined a comprehensive Clare Ward weekly audit between 7 November and 4 December 2012 looking at risk assessment before Section 17 leave for one patient, and a selection of associated Section 17 leave plans. The Trust uses a standardised ward round proforma which has a section for Section 17 leave planning, updates and feedback.

4.94 In terms of Section 17 working practice we were informed that there are no routine Section 17 leave issues picked up in incident reviews. However, there is a current PFD regarding the death of a patient whilst on extended Section 17 leave with multiple recommendations.

[10] https://www.scie.org.uk/mca *The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. "Section 3(1) of the Mental Capacity Act 2005, provides the test of mental capacity as follows: (1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision; (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or(d) to communicate his decision (whether by talking, using sign language or any other means).*

4.95 The PFD states that whilst the patient's family were appropriately informed and involved in the decisions and aware of the plan at the time of discharge, no contact made with the local community services. Trust guidance was ambiguous about whether such contact should be made and assessments and plans were not revisited when there was a change in circumstances.

4.96 As a result of the PFD report, the Trust Clinical Risk Assessment and Management of Harm Policy was reviewed, updated and came into effect in June 2018 including an appendix for risk management within teams and services.

4.97 The Trust Section 17 Leave Policy was reviewed, updated and ratified in October 2017 and came into effect in March 2018. This now includes guidance and policy regarding patients on Section 17 extended leave, and a leave policy for informal patients. The ward round structure on Clare Ward was reviewed to ensure that patients on Section 17 leave are routinely discussed and that this is fully documented on the electronic car record system.

4.98 Clare Ward use periods of long leave as trial leave for patients, planned within the ward round as part of the discharge planning, usually with the support of the HTT to support the patient whilst on leave with agreement regarding review. If the patient refuses HTT input leave would be planned with follow up support by the CMHT.

4.99 Patients on leave are discussed daily within the 'Red to Green' multidisciplinary meeting. A senior HTT Liaison Nurse attends this and updates the ward and the Trust of patients on leave. Any concerns would be raised in this meeting and would be discussed in the urgent meeting immediately following this.

4.100 We were informed about further learning from another serious incident regarding Section 17 leave, where the ward system for signing patients in and out of the ward was unclear. This has meant that since 2018 Clare ward has used a new signing in and out sheet for all patients going on leave including a series of questions to form a dynamic risk assessment of current mental state and behaviour including vulnerability, crisis plans and care plans.

4.101 In summary, we therefore found adequate assurance to meet this action and have therefore graded this as 'C' being completed. However, due to the PFD report and the further incident regarding Section 17 leave on Clare Ward, we have not been able to find adequate assurance, at this stage, that Section 17 leave practice is embedded.

4.102 We expect that further audit and scrutiny through the Trust and Clare Ward level performance framework will provide this assurance in due course.

4.103 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area through the Trust serious incident action plan group.

Trust Action five

Number	Original Report Recommendation	Trust Action	Niche Grading
5	Clare ward to review the supervision processes on the ward and ensure that a review of named nurse clients are included in the process and supervision notes.	The ward will complete a review of supervision structures and provide evidence of structure following review. The ward will use a uniform supervision template for all ward staff including the ward manager. This template will include explicit expectation of named nurse interventions with their patients. Additional assurance will be provided by supervision to be audited monthly and presented to performance meeting with deputy director acute care pathway. Evidence of three-month cycle of audit presentation. Twelve-month review to demonstrate that this has been embedded.	C

4.104 In assessing whether a review of supervision structures, the use of a supervision template with named nurse interventions, and regular audit of supervision had been actioned we spoke to staff and reviewed Clare Ward supervision structures and process, in the context of the Trust Supervision Policy (version five ratified 1 June 2018, review August 2021) and staff appraisal information.

4.105 We reviewed the CQC Inspection Report in January 2017 where it was found that staff supervision rates were low. The CQC Inspection Report October 2018 stated that in some wards and teams, managers did not hold regular supervision meetings with staff to monitor the effectiveness of their work and provide timely support.

4.106 However, the National Staff Survey 2017 found that the percentage of Trust staff appraised in the previous 12 months was 94 percent against a national average of 89 percent. The CQC also found that staff had completed the Trust's new annual performance appraisal or were booked to do so.

4.107 At the October 2018 inspection, the CQC found that supervision rates continued to be low with 52 percent of staff receiving supervision in accordance with the Trust's Policy in the year from March 2017 to February 2018. Although this improved between April to June 2018 to 75 percent, nearly one quarter of the acute wards had completed less than 65 percent of

planned staff supervision in that period. This made it difficult for managers to provide support to staff and address their development needs.

4.108 We viewed a document (undated) which reviewed the specific supervision arrangements on Clare Ward. This included a brief reflection and guidance on areas for review in supervision sessions and a supervision 'contract' between the supervisor and supervisee. We spoke to a Band five nurse on Clare Ward who confirmed that risk discussions took place in regular supervision.

4.109 We were informed that Clare Ward use the Trust supervision template which has recently been streamlined and can be modified to meet local needs. The Trust expectation is that supervision will take place every four to six weeks.

4.110 During supervision, primary nurse expectations and tasks are discussed. If there are any shortfalls in performance, appropriate arrangements are put in place with additional training and or one to one support.

4.111 Rates of supervision are reviewed in monthly performance meetings and are recorded onto an electronic system to aid central reporting. Apart from one to one supervision, other forms of supervision include use of incident review meetings, psychology sessions, group meetings and reflective practice.

4.112 Our view is that this action has been implemented, and we have graded this as 'C', however there is not enough assurance to indicate that supervision is embedded in practice. We are satisfied that the Trust has central performance systems in place to monitor supervision rates and that this will be addressed through the Trust action plan in response to the CQC Inspection Report October 2018.

4.113 Our view is that the impact of this action will be reviewed through the National Staff Survey and have no further recommendation to make in respect of this.

Trust Action six

Number	Original Report Recommendation	Trust Action	Niche Grading
6	The triage Ward Managers and Consultant to ensure there are systems in place to address any missing documentation to assure them that all patients have care plans risk assessments that address the plans made in ward rounds.	All risk assessments will be monitored through the inpatient dashboard. Clinical Service Lead to review and monitor dashboard for completion rates weekly. All qualified staff will have completed mandatory training on risk assessment. Band six nurse to complete monthly audit. Quality will be monitored through audit on each ward. Ward managers will ensure that risk assessment is a mandatory area for supervision. Ward Manager to ensure system for supervision is robustly followed external to the service area via Clinical Service Lead. Additional oversight will be provided by CAG governance forum on a monthly basis. Evidence of completion of three audit cycles required to show implementation and action taken. CAG to review in 12 months.	C

4.114 To review this action, we refer to our findings for Trust action four in terms of risk assessment and training and our findings for Trust action five for supervision systems.

4.115 Specifically, in terms of risk assessment documentation and training, we found adequate assurance to meet this action and have therefore graded this as ‘C’ being completed. However, given the recent learning from a serious incident and a PFD, we are not able to find adequate assurance at this stage that Section 17 leave practice is embedded.

4.116 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through the Trust serious incident action planning group.

4.117 In terms of supervision, we found that this action has been implemented, and we have graded this as ‘C’, however there is not enough assurance to indicate that supervision is embedded in practice. We are satisfied that this will be addressed through the Trust action plan in response to the CQC Inspection report October 2018 and the impact of this will be reviewed through the National Staff Survey results. We have no further recommendation to make.

Trust Action seven

Number	Original Report Recommendation	Trust Action	Niche Grading
7	Clare Ward leadership team to develop information leaflets for patients families.	Clare Ward will develop information leaflets for patient families. This will embed provision for separate meetings for families and carers to be facilitated on all wards, where this is consistent with the patients capacity if permission is given, or best interests if capacity is lacking.	B

4.118 To review whether Clare Ward has developed information leaflets for patient families, embedding provision for separate meetings for families and carers, we spoke to staff, reviewed the information and leaflet available for carers, and to place this action in context, examined Trust quality priorities for carer and family engagement.

4.119 We note the Trust Annual Report 2017-18 states that one of the quality priorities for 2018 -19 is to increase the number of identified carers, friends or family for the person in receipt of care and that this will be monitored monthly. The aim is that within three years, the Trust will routinely involve carers in service re-design, improvement, governance and the planning and delivery of their loved ones care.

4.120 Specifically, the Trust will measure the numbers of identified carers, and, or, friends and family; measure the number of care plans that have been devised collaboratively with the service user and that the contents have been shared with them.

4.121 We note the CQC Inspection Report October 2018 states that the Trust actively encourages patients and carers to be involved in care planning and seeks their views on a range of aspects of their care and treatment. The Trust acted on feedback from patients and carers to make improvements to the service. The Trust facilitates service user and carer advisory groups as a way of involving them in the development of the service.

4.122 Staff told us that they had identified a member of staff on Clare Ward who took a lead on carers' involvement and held monthly carers' forums. We viewed carers' information on a notice board at the entrance to Clare Ward.

4.123 The Clare Ward information board provided comprehensive information for carers including:

- Friends and Family Test;
- the carers information leaflet;
- the Trust carers charter'
- a guide to joining the Trust involvement register, confidentiality and sharing information with carers;
- a practical guide to healthy caring;

- details of a mental health carers and families support group;
- Carers Lewisham; and
- The Trust 24 hour crisis line.

4.124 The Ladywell Unit information pack for patients contained information about support for carers, working with carers to make an engagement and support plan, carers' assessments, involving family members and carers and how to get in touch. Specifically, it contains a paragraph inviting carers to ward rounds to meet the Consultant Psychiatrist; and offered further opportunities to meet junior doctors on the ward.

4.125 The Trust Families and Carers' Handbook contains a section providing information about listening to carers, consent and confidentiality and how best to involve the carer.

4.126 We have therefore graded this action as 'B' having been implemented, and embedded in practice. However, feedback from the family for the purposes of this review suggests that information for carers should include Section 17 leave.

4.127 In terms of taking this forward and impact, we are satisfied that the Trust will address this through the processes for the delivery of the specific quality priority for 2018 -19 to routinely involve carers in the planning and delivery of their loved ones care.

Trust Action eight

Number	Original Report Recommendation	Trust Action	Niche Grading
8	Trust-wide. Professional Leads for each CAG will enlist the help of experts in ASD to be considered when a patient with ASD is admitted to hospital. Pathways for obtaining this expertise to be clarified.	Green light tool kit actions to be put in place by Clinical Service Leads and Professional Leads.	D

4.128 We reviewed the Trust provision of ASD services and note the Trust has a Mental Health Learning Disability Service (MHLD) working closely with the local health Community Teams for Adults with Learning Disabilities (CLDTs), Social Services and local mental health services. We note that the services for learning disability and autism are separate, however with similarities and links between the two.

4.129 At a clinical level the service offers highly specialised assessment, advice, treatment and prevention of mental health problems. Interventions may be home or outpatient based, depending on the needs of the individual. The MHLD Service uses all the facilities of mainstream mental health services, including acute and medium stay in-patient beds, and a variety of community resources. The service offers a variety of therapies such as cognitive behaviour therapy, counselling and positive behavioural interventions.

4.130 The Trust also has a National Autism Unit for adults with ASD who have

additional mental health difficulties and offending or challenging behaviour, based at the Bethlem Royal Hospital in Beckenham. The inpatient team includes highly skilled, multi-professional senior clinicians and internationally renowned academics, working together to translate cutting edge research into best clinical practice. Committed to facilitating rapid recover, and assist patients in the transition towards a less restrictive community setting. There is also an associated National Outpatient Diagnostic Unit.

4.131 We note that the Trust clinical services work closely with the Estia Centre[11] to improve the care of people with learning disabilities, especially those with additional mental health and challenging needs through evidence-based practice.

4.132 We note that the Trust Annual Report 2017-18 states that one of the Acute Care CAG objectives is to improve access and experiences for service users with learning disabilities in acute wards. We found that the Care Quality Commission Inspection Report July 2017 rated the wards for people with a learning disability or autism as outstanding in effective, caring, well led and good in safe and responsive domains with an overall outstanding rating.

4.133 However, we note that the CQC Inspection Report October 2018 stated that the Trust should ensure ward staff receive training in autism. The CQC found that the service did not provide adequate support to staff to ensure they had the necessary skills to support patients effectively.

4.134 Although staff had access to training in caring for people with learning disabilities this did not include patients with autism, although staff told the CQC that patients with autism were admitted to the wards.

4.135 Staff told us about positive developments in that Clare Ward now had a Learning Disability Lead Nurse on the ward. The Trust has appointed a Service Lead for Mental Health Learning Disability and Autism, and a Consultant Nurse Learning Disability with the aim of delivering the Greenlight Toolkit,[12] the Learning Disability Improvement Standards[13] and to develop training and provide direct clinical support.

4.136 However, in terms of access to ASD expertise staff told us that, although there had been an ASD clinic in Lewisham, the Consultant Psychiatrist had left Trust employment a few months previously. They said they would like more resources, although they can ask for a second opinion if required.

4.137 We have graded this action as 'D' being partially implemented with the Consultant Nurse in Learning Disability appointed to deliver on the Greenlight Toolkit and the Learning Disability Improvement Standards, however given the CQC findings, we found that the action was not completed, embedded in

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[11] *https://www.slam.nhs.uk/about-us/clinical-academic-groups/behavioural-and-developmental/estia/what-we-do*

[12] *https://www.ndti.org.uk/uploads/files/Green_Light_Toolkit_22_Nov_2013_final.pdf A guide to auditing and improving mental health services so that it is effective in supporting people with autism and people with learning disabilities.*

[13] https://improvement.nhs.uk/resources/learning-disability-improvement-standards-nhs-trusts/ *new standards to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both.*

practice or having an impact as yet.

4.138 We expect the Trust action plan against the CQC Inspection report October 2018 to ensure ward staff receive training in autism will address these issues. We have no further recommendations to make.

DHR recommendation nine

Number	Original Report Recommendation	Trust Action	Niche Grading
DHR 9	The Trust to review its response to domestic abuse, covering staff awareness and availability of training, the effectiveness and impact of policies and procedures, the identification of victims and perpetrators, risk identification and referral, and safe and appropriate ongoing work with those individuals including multi-agency working, and for a mechanism to be put in place for ongoing monitoring of the response.	N/A	B

4.139 To assess whether the Trust had reviewed it's response to domestic abuse and put in place a mechanism for the ongoing monitoring of the response, we spoke to staff, examined Trust Adult Safeguarding and Domestic Violence Policies, and reviewed the Lewisham Adult Safeguarding Board meeting minutes and Annual Report 2017- 2018.

4.140 We note the Trust Adult Safeguarding Policy (version 2.3 ratified May 2016, review April 2019) refers to additional guidance 'Adult Safeguarding and Domestic Abuse - A guide to support practitioners and managers' (ADASS 2015) and the Trust Domestic Violence Policy.

4.141 The Trust Domestic Abuse Policy (version 2.3 ratified February 2017, review October 2019) includes sections on signs of domestic abuse, creating an environment for disclosing domestic violence and abuse, the identification of victims and perpetrators, response and risk assessment following disclosure and safety planning, a checklist to identify high risk cases and risk identification and referral.

4.142 The policy states that all clinical staff are giving a brief introduction to domestic violence and abuse as part of both safeguarding children and adults mandatory training. In addition to this, additional guidance around domestic abuse is accessible to staff on the Trust Intranet system.

4.143 Domestic abuse training is available for all staff via internal LEAP training system (see 4.85). All staff are encouraged to access domestic abuse training provided by local safeguarding children boards and safeguarding partners. We were informed that a domestic abuse conference for staff to is be held in October 2019 and that the safeguarding lead for perinatal services has procured a stand-alone budget to provide specific training for perinatal mental health staff commencing April 2019.

4.144 We were informed that the Trust endorses the 'Think Family'[14] strategy across all services and that Safeguarding Leads are now established in each Borough to provide consultation and advice to staff, that there is a Trust-wide Named Nurse for Safeguarding Children and a Trust-wide Named Professional for Safeguarding Adults available for staff to contact for consultation and advice.

4.145 We were informed that the Trust now has a Domestic Violence Steering Group which meets quarterly to consider the organisational responsibilities, duties and ongoing practice. The Trust Safeguarding Committee has distinct sections between safeguarding children and safeguarding adult committees for domestic violence.

4.146 In terms of the identification of victims and perpetrators, risk identification and referral we were informed that risk assessment incorporates staff analysis, recording and planning around domestic abuse concerns. The child risk screen incorporates assessment and consideration of domestic abuse and the impact on children and young people.

4.147 The Trust DATIX serious incident recording system incorporates the flagging of incidents of domestic abuse (relating to victim survivor, child and, or perpetrator) known to the Trust. The flagging system for risk is located on the front sheet of the electronic care record; this could relate to victim, survivor, children and, or the perpetrator known to the Trust.

4.148 We note from the LSAB Annual Report 2017-2018 that the Trust are active members of the LSAB and undertook a safeguarding audit showing positive results of staff awareness of safeguarding reporting and recording.

4.149 The Trust Annual Report 2017-2018 stated, in more detail, that the audit assessed compliance with the Trust Safeguarding Adults Policy, examining good safeguarding practices and the extent of recording. A separate audit was completed to assess staff understanding of their safeguarding responsibilities.

4.150 There was evidence of good documentation compliance and high compliance with staff completion of the Safeguarding Adults training. However, some evidence was not always documented. Not all staff members who took part in the survey knew who their Safeguarding Lead was. Very few staff also reported that adults at risk had been involved in the safeguarding process when a concern was raised.

4.151 In terms of safe and appropriate ongoing work with those individuals including multi-agency working, the audit was presented and discussed at the Trust Safeguarding Adults Committee where recommendations were agreed to address the gaps highlighted. This included raising staff awareness around Multi-agency Risk Assessment Conference[15] (MARAC)

[14] https://www.scie.org.uk/publications/ataglance/ataglance09.asp *encourages the development of services that offer an open door into a system of joined-up support at every point of entry, look at the whole family and co-ordinate care, and provide support that is tailored to need and builds on family strengths.*

[15] https://www.reducingtherisk.org.uk/cms/content/marac *A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed.*

referrals and flagging and tagging cases on electronic systems.

4.152 We were informed that the Trust MARAC meeting is reviewing MARAC processes across the Trust, multi-agency working and how representatives disseminate best practice to staff. There are nominated MARAC leads in each Borough to support practitioners to make referrals to MARAC.

4.153 The Trust Annual Report states that the Trust and Lewisham CCG have agreed a standard set of safeguarding adult quality indicators, reported quarterly, broken down by clinical incident with concerns relating to alleged abuse or neglect and mandatory training data.

4.154 The Trust Annual Report states that in 2018-2019 the Trust plans to use business intelligence reports to help local operational services maintain better oversight and governance of their safeguarding work.

4.155 The Trust stated that they will embed learning by clarifying and improving the interface between operational serious incident investigation governance systems and safeguarding.

4.156 A new system has been agreed for logging and documenting serious case reviews, safeguarding adult reviews and domestic homicides. Governance arrangements for operational oversight and monitoring of action plans are being defined.

4.157 We found adequate assurance that the Trust had reviewed it's response to domestic abuse, and found comprehensive Trust Policies on Safeguarding Adults and Domestic Abuse and assurance regarding safeguarding training and recording of information through an audit cycle, monitored through the LSAB. We have therefore graded this action as 'B' being completed and embedded.

4.158 In terms of the impact of this action, we note that the LSAB discussed the headlines from the document entitled 'Learning from DHRs' and the need for ensuring key themes and lessons to be learnt from domestic homicides and other reviews are captured for frontline staff. It was suggested that learning and service development seminars would be a way to do this by looking at different complex scenarios, and that a Case Review sub-group would ensure the LSAB is well sighted on all serious events ensuring that they are being scrutinised.

4.159 We are satisfied that this will be addressed through the LSAB, and have no further recommendation to make.

DHR recommendation ten

Number	Original Report Recommendation	Trust action	Niche Grading
DHR 10	The Trust to report to the Safer Lewisham Partnership on the ways in which they have responded to the lessons learned about family concerns being acted upon during inpatient stays, and in particular in relation to risk assessment, planning for discharge and Section 17 leave.	N/A	E

4.160 To review whether the Trust had reported to the Safer Lewisham Partnership on the ways in which they have responded to the lessons learned, we reviewed the available minutes of this meeting during 2016-2017.

4.161 We could not find evidence that the Trust had reported as required and we have therefore graded this action as 'E' given there was not enough evidence to say that this had been completed.

4.162 We recommend that this action is reviewed as required through the Trust serious incident action planning group meeting.

DHR recommendation eleven

Number	Original Report Recommendation	Trust Action	Niche Grading
DHR 11	The Trust to review the systems in place in adult mental health wards for maintaining dialogue with inpatients GPs whilst they are on the ward. To feed back to the Safer Lewisham Partnership and to work with the CCG and NHS England as appropriate for taking any action needed to improve communication with GPs in Lewisham.	N/A	D

4.163 We found it difficult to source assurance on whether the Trust had reviewed systems for maintaining dialogue between inpatient services and GPs. We spoke to the Associate Director of Quality, NHS Lewisham CCG, and the Lewisham Head of Nursing and Quality who informed us that they were not aware of any specific action being taken to maintain dialogue with GPs, and we did not find evidence that the Trust had feedback to the Safer Lewisham Partnership on this issue.

4.164 However, we note the Trust Performance and Quality report January 2019 details that they use a system of 'Quality Alerts' to review and respond to concerns raised mainly by GPs (but also other health organisations or partners such as the police or third sector agencies) on behalf of their patients or clients.

4.165 We also note that Lewisham services have begun developing a partnership model which will deliver integrated mental health services across the

borough. The first service to develop this approach is the newly launched Primary Care Enhanced Service delivered in partnership with MIND. We were told that communication with GPs had improved through this strategic development.

4.166 Additionally, as a proxy for GP communication with the inpatient wards, we reviewed the Trust Annual report 2017-18 National Indicators for 2017 - 2018 which they are required to report performance against.

4.167 The Annual Report stated that against the CPA seven day follow-up National Indicator there continues to be a strong operational and performance focus with 97.5 percent compliance against a 95 percent target.

4.168 In terms of the National Indicator for Access to Crisis Resolution Home Treatment (HTT Gatekeeping, re-admission to hospital within 28 days of discharge) 99.9 percent were 'gate-kept' prior to admission in 2017 - 2018. The Trust noted that the ARC is fully operational and all patients are triaged through this system.

4.169 We reviewed the acute care pathway summary document in use in the inpatient wards and found that it contained care interventions aimed at preparation for discharge which included communication and correspondence with the GP.

4.170 We have therefore graded this action as 'D' being partially complete because we found a lack of a specific review of the systems in place in adult mental health wards for maintaining dialogue with inpatients GPs whilst they are on the ward.

4.171 We recommend that the Trust uses the quality improvement initiative, called 'Icare', which has already been working with staff to standardise ways of working for inpatient services, to progress this action to full implementation as required, and to assess the impact of this.

5 Summary

5.1 It is acknowledged that this homicide has had far reaching effects on the Trust. Due to the major structural change within the Trust commencing in 2016 through to the present day, and as new services bed down, we found it difficult to assess the assurance against the original report actions very specifically, as structures and systems have changed considerably.

5.2 In summary, previously the Trust organisational structure at the time of the incident was built around Clinical Academic Groups (CAGs), which were formed in 2010 to bring together clinical and academic expertise to develop and deliver care pathways across the whole spectrum of mental health conditions.

5.3 A Crisis Assessment Team was launched in December 2017, operating a triage system covering all four Trust Boroughs. Referrals are received from the Police or LAS staff, supporting diversion at the triage stage. For context, in the first four months of its operation, 289 assessments were carried out by the team, 96 of which were resolved without the need to attend A&E and

41 of which avoided the need to be taken to a place of safety by the police (Section 136 MHA).

5.4 The Trust has undertaken a further restructure with services and operational management being aligned to Boroughs whilst the CAGs continue to focus on research, new care pathways and new models of care. This restructure was planned to create integration and coherence to services and included a redesign of community provision with the transition period running from April to October 2018.

5.5 The seven CAGS, led by Academic and Clinical Directors now focus on quality improvement, education and training, evidence and research to enable the development of new clinical pathways. The associated quality improvement programme monitors the acute care pathway and implement improvements across all Trust services.

5.6 The Trust new operational directorates, such as in the Lewisham Borough, where Clare Ward is situated, are led by a Service Director. Services are described as being Borough focussed with specific, quality focussed care pathways.

5.7 As part of the restructuring process in the Lewisham Borough, in addition to the Service Director there are new senior clinical posts including a Medical Lead, a Head of Nursing and Quality, a Modern Matron and a Governance Lead. We were informed, as a result of the restructuring process and these new posts, that governance, leadership and escalation have been improved.

5.8 However, we note the Care Quality Commission (CQC) Inspection Report October 2018 stated that overall in the Trust the quality of leadership at a ward and team level was variable and was a key factor in whether the service was operating well.

5.9 The CQC stated that the Trust anticipated that the restructure of the operational directorates, resulting in smaller spans of control and increased levels of professional input, would deliver the support needed to make these improvements. We note that the Ward Manager on Clare Ward is newly appointed and has been in post since October 2018.

5.10 We have therefore assessed assurance as far as possible within Lewisham Borough, where applicable, and have provided further information about Trust assurance systems which have been put in place since then.

5.11 In terms of the eight Trust actions and three DHR recommendations we have summarised the Niche grading totals as follows:

Grade	Niche Criteria	Number
A	Evidence of completeness, embeddedness and impact.	1
B	Evidence of completeness and embeddedness.	4
C	Evidence of completeness.	3

D	Partially complete.	2
E	Not enough evidence to say complete.	1
	Total number of actions	11

5.12 Where the action resulted in a grading of B, C, D or E we have made residual recommendations for the Trust to seek formal assurance of the completeness, embeddedness and impact against each action as appropriate.

Residual recommendations

Trust action one

5.13 We found adequate assurance to meet this action and have therefore graded this as 'A' being completed, embedded and having an impact. No further recommendations are made.

Trust action two

5.14 We found adequate assurance to meet this action and have therefore graded this as 'B' being completed and embedded in practice.

5.15 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through compliments, complaints or the National Inpatient Survey.

Trust action three

5.16 We found adequate assurance to meet this action and have therefore graded this as 'B' being completed and embedded in practice.

5.17 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through compliments, complaints or the National Inpatient Survey.

Trust action four

5.18 We found adequate assurance to meet these actions and have therefore graded this as 'C' being completed. However, we have not been able to find adequate assurance at this stage that working practice regarding the conducting of risk assessments prior to a patient taking Section 17 leave is embedded in practice.

5.19 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area through the Trust Serious Incident Action Plan Group.

Trust action five

5.20 Our view is that this action has been implemented, and we have graded this as 'C', however there is not enough assurance to indicate that supervision is embedded in practice. We are satisfied that the impact of this will be

reviewed through the National Staff Survey and have no further recommendation to make in respect of this.

Trust action six

5.21 In terms of risk assessment documentation and training, we found adequate assurance to meet this action and have therefore graded this as 'C' being completed. However, given the recent learning from a serious incident and a PFD, we are not able to find adequate assurance at this stage that working practice regarding the conducting of risk assessments prior to a patient taking Section 17 leave is embedded in practice.

5.22 In terms of the impact of this action, the Trust should consider the available assurance to assist in this area, which may be through the Trust Serious Incident Action Plan Group.

5.23 In terms of supervision, we found that this action has been implemented, and we have graded this as 'C', however there is not enough assurance to indicate that supervision is embedded in practice. We are satisfied that the impact of this will be reviewed through the National Staff Survey and have no further recommendation to make in respect of this.

Trust action seven

5.24 We have graded this action as 'B' having been implemented, and embedded in practice. However, feedback from the family for the purposes of this review suggests that information for carers should include Section 17 leave. In terms of taking this forward and impact, we are satisfied that the Trust will address this through the processes for the delivery of the specific quality priority for 2018 -19 to routinely involve carers in the planning and delivery of their loved ones care.

Trust action eight

5.25 We have graded this action as 'D' being partially implemented with the Consultant Nurse in Learning Disability appointed to deliver on the Greenlight Toolkit and the Learning Disability Improvement Standards, however given the CQC findings, we found that the action was not completed, embedded in practice or having an impact as yet.

5.26 We expect the Trust action plan against the CQC Inspection report October 2018 to ensure ward staff receive training in autism will address these issues. We have no further recommendations to make.

DHR recommendation nine

5.27 Although we could not source assurance of a specific review of the Trust response to domestic abuse, we found the Trust Policies on Safeguarding Adults and Domestic Abuse were comprehensive, and we found assurance regarding safeguarding training and recording of information through an audit cycle, monitored through the LSAB. We have therefore graded this action as 'B' being completed and embedded.

5.28 The LSAB discussed the headlines from the document entitled 'Learning from DHRs' and the need for ensuring key themes and lessons to be learnt from domestic homicides and other reviews are captured for frontline staff. It was suggested that learning and service development seminars would be a way to do this by looking at different complex scenarios, and that a Case Review sub-group would ensure the LSAB is well sighted on all serious events ensuring that they are being scrutinised.

5.29 In terms of the impact of this action we are satisfied that this will be addressed, through the LSAB. We have no further recommendation to make.

DHR recommendation ten

5.30 We could not find evidence that the Trust had reported as required and we have therefore graded this action as 'E' given that there is not enough evidence to say that this had been completed.

5.31 We recommend that this action is progressed to implementation, and the impact assessed, as required through the Trust Serious Incident Group Action Plan Assurance Meeting.

DHR recommendation eleven

5.32 We have graded this action as D being partially complete because we found a lack of a specific review of the systems in place in adult mental health wards for maintaining dialogue with inpatients GPs whilst they are on the ward.

5.33 We recommend that the Trust uses the quality improvement initiative, called Icare, which has already been working with staff to standardise ways of working for inpatient services, to progress this action to full implementation as required, and to assess the impact of this.

Appendix A - Terms of reference

1. Purpose of the Review

To independently review the progress and implementation of actions by the Trust from the internal investigation into the care and treatment of J, the Domestic Homicide Review and the embedding of learning across the Trust and identify any other areas of learning for the Trust and/or CCG. The outcome of this review will be managed through governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

2. Terms of Reference

2.1 Review the implementation of the Trust's internal investigation action plan, in particular:

- Review progress made against the action plan.
- Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services.
- Comment on the CCG monitoring of the action plan.
- Make further recommendation for improvement as appropriate.

2.2 Review the Trusts actions following the Domestic Homicide Review and processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

3. Timescale

The review process starts when the investigator receives the Trust documents and the review should be completed within 6 months thereafter.

4. Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.
- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

5. Outputs

5.1 A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

5.2 At the end of the review, to share the report with the Trust and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.

5.3 A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

5.4 We will require monthly updates and where required, these to be shared with families, CCGs and Providers.

5.5 The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate.

Appendix B – People Interviewed

Designation	Date
Associate Director of Quality NHS Lewisham Clinical Commissioning Group.	11 January 2019
Consultant Psychiatrist Clare Ward	5 February 2019
Ward Manager Clare Ward	5 February 2019
Lewisham Modern Matron	5 February 2019
Lewisham Head of Nursing	5 February 2019
Head of Patient Safety	5 March 2019
Deputy Director of Nursing	5 March 2019
Consultant Nurse Learning Disability	2 April 2019

Appendix C – Documents reviewed

	Document	Date
1	Reasonable adjustments	2012
2	Greenlight toolkit information	2013
3	Carers Handbook	2013 - 2015
4	Trust serious incident panel terms of reference	2014
5	Domestic Homicide Review	July 2015
6	Serious incident closure checklist	2015
7	Trust learning lessons quarter 2	2015 – 16
8	Clare Ward MHA Ward reviews	2016
9	Clare Ward training log	April 2016
10	Clare Ward Business Meeting	5 April 2016
11	Pre – leave risk assessment	7 November 2016
12	Trust Panel of Inquiry Internal Investigation Report	22 November 2016
13	Acute CAG two year plan	13 December 2016
14	Learning lessons quarter 2	2016 - 17
15	Selection of care plans	2017
16	Care plan and risk audit	January 2017
17	EPJS Audit (dashboard)	4 January 2017
18	Annual CAG review	9 January 2017
19	HTT Operational Policy	March 2017
20	Trust Annual Reports	2015-2016 2016-2017
21	Trust serious incident panel meeting	June 2017
22	Lewisham Directorate Action plan assurance meeting	14 November 2017
23	Triage centre care plan audit	October 2017 – August 2018
24	Clare Ward care plan audits scores	August 2018
25	Trust SIRG agenda	23 August 2017 29 June 2017 14 December 2018
26	Learning Disability Improvement Standards	June 2018
27	Clinical Risk Assessment and Management of Harm Policy	Version 7.3 June 2018
28	Supervision policy	Version 5 June 2018
29	CCG feedback on the Trust serious incident review arrangements	September 2018
30	Trust Board performance and quality paper	19 November 2018
31	Care Plan and Risk Screen	Undated
32	Clare Ward bed management telephone referrals	Undated
33	Acute Care Pathway Summary	Undated
34	Acute Pathway on Admission	Undated
35	Clare Ward carers leaflet	Undated
36	Trust carers handbook	
37	Review of supervision guidelines	Undated

38	Supervision template	Undated
39	Nurse Consultant Learning Disabilities job description	Undated
40	Trust Board Reports	Various