

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Follow-up review of a statutory mental health independent homicide investigation: Mr T and Mr U

Berkshire Healthcare NHS Foundation Trust

A report for
NHS England, South Region

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1 Introduction

NHS England has commissioned Verita to undertake follow-up reviews of statutory mental health independent homicide investigations. The purpose of the reviews is to provide assurance that the recommendations from the investigations have been implemented or are in the process of being implemented. Berkshire Healthcare NHS Foundation Trust (the trust) is one of the trusts involved in the follow-up reviews.

In this report we review actions arising out of the Verita investigation into the care of Mr T and Mr U. Mr T, a former service user, along with two others, stabbed to death Mr U, another service-user, on 16 March 2012 in Mr U's flat in a supported housing complex.

Mr T received three separate episodes of care from the trust. His most recent period of treatment and care was from Newbury Community Mental Health Team (CMHT). He had referred himself to the service on 21 November 2011. He was last seen in February 2012 and discharged into the care of probation and his GP. He was subsequently charged along with two other people with the murder of Mr U.

Mr U had a long forensic history. He had been in and out of youth offender units and prison since he was 13. He had also received care and treatment from the trust and was under the care of Newbury CMHT at the time of the incident. He was also receiving support from Turning Point (a national social care provider) and from probation services.

In our independent investigation we concluded that the incident could not have been predicted or prevented. We found nothing in Mr T's words, actions or behaviour at the time that could have warned professionals that he might imminently become violent. Mr T did not present in a way that indicated that he should have been admitted to hospital. We found other areas of treatment and care that could have been improved.

In undertaking this follow-up review, we were concerned not to revisit the findings of the independent investigation. The purpose of this review is to give assurance to NHS England, families and clinical commissioning groups (CCGs) that recommendations have been implemented and to draw attention to any areas of concern.

2 Recommendations from the Verita independent investigation

R1 The trust should ensure that the work of the short-term team is integrated into the secondary mental health services and its function is clearly understood.

R2 The trust should negotiate with key partners a policy/protocol that sets out when a multiagency review meeting should be called.

R3 The trust should issue a practice guidance note reminding all staff that a referral for a psychiatric assessment should always be made if requested. If a referral is not to be made a recorded rationale for why must be placed on the patient's notes.

R4 The trust board should commission a report that will provide it with robust evidence of the quality and compliance level of risk assessments.

R5 Senior trust managers should negotiate with senior managers from partner agencies the level of information sharing at Multi Agency Public Protection Arrangement (MAPPA) meetings to ensure it is consistent with national good practice.

R6 The trust should seek agreement with partner agencies for a joint protocol governing when an interagency investigation is required and how it should be conducted. This should clearly set out the role of the lead agency and expectations of the other agencies contributing to the investigation. This would not affect individual agency requirements to conduct their own inquiries.

R7 The trust should ensure that a person in a direct-line management relationship or in the locality/directorate does not undertake investigations with the service under investigation. An investigation must be conducted by a suitably trained individual who is clear about its role and function.

R8 The trust should develop and implement a strategy for improving record keeping.

R9 The trust should amend its policy for investigating serious incidents and reporting on them to ensure sufficient challenge and scrutiny are built into the process. The board, including non-executive directors, should receive a full report from all level 5 incidents as well as themed reports. The board should be able to assure itself about the progress of recommendations from all serious incidents.

3 Terms of reference of the follow-up review

- To conduct an independent review on the implementation of the action plan following the homicide investigation.
- To inform NHS England and the clinical commissioning group of any concerns resulting from the audit.
- Produce a short report to be shared with stakeholders, including families, the trust and the clinical commissioning group and published by NHS England.

4 Methodology and structure

We reviewed key documents (appendix A) and interviewed senior managers from the trust (appendix B) to assess progress in implementing the recommendations from the initial investigation and monitoring service changes.

For the purposes of this follow-up review, we grouped the recommendations as follows:

- recommendations relating to interagency work [R2, R5 and R6];
- recommendations relating to the governance of trust investigations [R7 and R9]; and
- recommendations relating to operational issues [R1, R3 and R8].

We did not review the implementation of recommendation 4 as this is the subject of a separate Verita report.

Recommendations relating to interagency work are reviewed in section 6. Those relating to the governance of trust investigations are covered in section 7 and operational issues in section 8. Overall conclusions are given in section 9.

The review was carried out by Andy Nash, Verita Associate, with assistance from Geoff Brennan (Senior Consultant).

5 Findings and recommendations of the follow-up review

5.1 Findings

F1 The trust assured us that multiagency professionals meetings are routinely happening though the arrangements for these are not subject to a multiagency policy/protocol agreed with key partners. Only a trust policy sets out these arrangements.

F2 The specific issue of information sharing between agencies at MAPPA meetings is resolved. It is of some concern that this took a year and needed the intervention of the trust's Chief Executive.

F3 The trust has developed a protocol that governs when a multiagency review should take place. This is not a signed, formal multiagency agreement but senior managers told us that all the statutory agencies were in agreement with it.

F4 The trust has assured us that investigating officers no longer undertake investigations in their own services. All investigations are now conducted by suitably trained individuals who are clear about their role and function.

F5 The trust has established a robust process for ensuring that sufficient board-level scrutiny and challenge is built into the investigation process.

F6 The short-term team is now integrated into the overall team structure and has medical input. The team provides a range of social interventions, the Approved Mental Health Professional (AMHP) service and a duty service. However, we still have some concerns about the role and function of the team.

F7 We found the care pathway structure difficult to understand.

F8 The Local Authority, which fund the short term team, are conducting a major review of all services which will include the short term team. The trust is awaiting information the outcome of this review.

F9 The trust has issued a practice guidance note reminding all staff that a referral for a psychiatric assessment should always be made if requested.

F10 The trust has a comprehensive strategy and action plan for improving record keeping. There are signs of improvement but this needs to be seen in the context of the trust starting from a low base.

5.2 Recommendations

R1 The trust should set out in its care pathways policy and its risk assessment and management policy when a multiagency professionals meeting should be called and agree this with key partners.

R2 The trust should clarify the role and function of the short-term team following the local authority review.

R3 The trust should review the *Care pathways operational manual* to ensure that the care pathway structure can easily be understood.

6 Recommendations relating to interagency work

6.1 The trust should negotiate with key partners a policy/protocol that sets out when a multiagency review meeting should be called. [R2]

This recommendation relates to our finding that there did not appear to be an established process whereby professionals at the trust either attended professionals meetings with other agencies or called such meetings.

6.1.1 Background from Verita's independent homicide investigation report

"The two CPNs who saw Mr T in November 2011 told us that on reflecting on this case they agreed that a more coordinated approach to the care of Mr T (for example by having a multiagency planning meeting) might have helped coordinate the various agency inputs. They also agreed that he might have been eligible for a MAPPA¹ referral and so might have been referred into Care Pathways² , as opposed to the short-term team." (Page 22)

"There was a fair degree of information sharing and joint meetings between local authority children and families team, probation and health visiting about Mr T and his family. The mental health team were not involved in meetings, but did share information on an ad hoc basis. Mr T's difficulty with anger and his possible mental health issues could have had an impact on the safeguarding arrangements for his partner and children. In these circumstances, a multiagency review that included mental health service staff was warranted and should have taken place." (Page 23)

The trust's action plan notes that "Risk Assessment and Management ...policy will be revised ...including when to consider calling a multiagency meeting". The action plan notes that the implementation of this action was completed on 8 December 2014.

The revised policy states:

"4.8 All qualified and appropriately trained staff should be proactive in information sharing with other agencies if doing so enhances the safety of the service user and/or the safety of the public."

"5.7 The care coordinator is responsible for monitoring the agreed risk management plan and joint working across service areas/agencies when relevant."

¹ Multi Agency Public Protection Arrangements (MAPPA) ensure the successful management of violent and sexual offenders.

² The Care Pathways Team is the local multidisciplinary and multiagency team providing services within West Berkshire for those who require secondary mental health services.

“7.1 Effective risk management involves sharing information with other agencies. Information should be shared on a need to know basis, and a ‘what they need to know’ criteria.”

The policy sets out responsibilities in respect of MAPPA (section 11.1) and safeguarding children (section 13) though not adult safeguarding.

In our interview with the Director of Nursing and Governance she told us that this recommendation was not specifically addressed in the policy and that the focus had been on ensuring that MAPPA, safeguarding¹ and domestic violence interagency arrangements are working according to national policy. She told us that trust multidisciplinary team meetings can call interagency professionals meetings and that she was confident that such meetings are being routinely called. Furthermore, she told us that trust management considered it good practice for multiagency review meetings to be called and expected this to happen.

The Head of Mental Health for West Berkshire also confirmed that interagency professionals meetings are called on a regular basis and that she has attended them. She explained that meetings are called when coordination is required or if there are difficulties working with a particular service user. She told us that any member of staff can call a multiagency meeting and that housing services often call meetings with the trust and police when necessary.

We were shown an example of an interagency meeting. These meetings are called where:

“Multiple agencies involved with a patient and the care needing co-ordinating, common goals being identified.

- Difficult to manage patients splitting the teams involved in their care, a meeting of this nature will allow for greater planning and understanding of the requirements of each service/professional.
- If concerns are being raised by one agency who requires support from another service.
- If a patient is difficult to engage, consideration to having a joint approach/joint visits.”²

She accepted that these arrangements should be subject to policy and suggested that they should be in the trust’s care pathways policy.

We could not find in the policy where it sets out when a multiagency professionals meeting should be called outside of the statutory frameworks cited. Such meetings enable professionals to share information both to improve care but also to determine, for example, whether there is information known to one agency but not to others.

¹ Safeguarding means protecting people's health, wellbeing and human rights, and processes to follow if there is a threat of harm, abuse or neglect.

² Note attached to minutes of multiagency meeting.

6.1.2 Finding

F1 The trust assured us that multiagency professionals meetings are routinely happening though the arrangements for these are not subject to a multiagency policy/protocol agreed with key partners. Only a trust policy sets out these arrangements.

6.1.3 Recommendation

R1 The trust should set out in its care pathways policy and its risk assessment and management policy when a multiagency professionals meeting should be called and agree this with key partners.

6.2 Senior trust managers should negotiate with senior managers from partner agencies the level of information sharing at Multi Agency Public Protection Arrangement (MAPPA) meetings to ensure it is consistent with national good practice. [R5]

This recommendation was about the lack of clarity about information sharing at MAPPA meetings and the distribution of minutes.

6.2.1 Background from Verita's independent report

"The children's and families managers told us that attendees at MAPPA meetings were not permitted to record information-only actions for their agency. Meetings were recorded and written minutes taken but not distributed. The MAPPA meeting joint chairs came from probation and the police."

"We found considerable confusion and a lack of understanding from both local and trust level managers about the actual processes for sharing MAPPA information. MAPPA is a key safety process in a locality and the level of information-sharing described seems unusual and not consistent with practices in other areas, where minutes are shared with all relevant agencies/professionals."

"There is a policy (Multi Agency Public Protection Arrangements (MAPPA), Memorandum of understanding, Thames Valley) covering the National Probation Service, HM Prison Service and Thames Valley Police (TVP). It is not dated and does not include the trust." (All quotes page 33)

Trust senior managers told us this had not been easy to negotiate and that the trust's Chief Executive had had to get involved. We were shown a letter dated 4 March 2015 from the Chief Executive to Thames Valley Police which states:

"A recent audit ... has uncovered a particular issue that is of concern with regard to meeting minutes. In particular it has come to light that the minutes of

the meeting are not circulated to the mental health representatives at the meeting, even in respect of cases where they have a key role in managing an individual under discussion. Proactive requests for copies have been denied.”

The police replied on 27 March saying:

“...as a ‘duty-to-cooperate’ agency you can be provided with a copy of the minutes if it is a case where you have direct involvement; your representatives should make this request at the meeting. It is not proportionate to send every set of minutes for every case and would present an unnecessary security risk.”

This was then followed by an email to senior trust staff from the Chief Executive on 7 May 2015:

“Please find confirmation that our reps at MAPPAs meeting should be receiving minutes pertaining to the cases where we have an interest. This is entirely in accord with the national MAPPAs guidance which our reps should also be familiar with. Can you now please ensure minutes on all cases where we have an involved (sic) are received in a timely fashion.”

We have had sight of minutes from the Quality Executive Group dated 8 June 2015, Item 12:

“MAPPAs Minutes – update from localities.

CE asked the Group that process is being followed and minutes are being received. CE reminded this is national policy. To be picked up again next month. Slough and Bracknell - both teams have always asked for the relevant notes at the meeting and have received with no issue.

CE checked on other areas: Reading – receives. West Berks – receives. WAM – receives. Wokingham – need to check.”

The Director of Nursing and Governance assured us that the issue has been resolved. She said that the trust is “much tighter about this issue” and that staff are more confident in dealing with MAPPAs meetings.

The Director of Nursing and Governance accepted that there had been a hold up on getting agreement between the trust and the police on sharing information at MAPPAs meetings. She told us that the trust had not got effective assurance from one particular locality about the problems with information sharing. Once it was established that there was an information sharing issue then the trust moved to resolve this problem.

She told us that the memorandum of understanding referred to on the previous page has not been updated to include the trust.

Comment

The trust's action plan notes that the implementation of this recommendation was completed on 11 August 2014 but the letter from the police confirming that trust staff can receive MAPPA minutes is dated 27 March 2015, seven months later. Our investigation report is dated March 2014. It effectively took a year to resolve an issue of national policy relating to high-risk individuals.

6.2.2 Finding

F2 The specific issue of information sharing between agencies at MAPPA meetings is resolved. It is of some concern that this took a year and needed the intervention of the Chief Executive of the trust.

6.3 The trust should seek agreement with partner agencies for a joint protocol governing when an interagency investigation is required and how it should be conducted. This should clearly set out the role of the lead agency and expectations of the other agencies contributing to the investigation. This would not affect individual agency requirements to conduct their own inquiries. [R6]

This recommendation arose out of our concern that a multiagency case review did not take place when Mr T killed Mr U.

6.3.1 Background from the Verita independent report

"...in this case there was some confusion about the commissioning of the investigation and the nature of what was required. Senior trust managers told us that an investigation into the care of both Mr T and Mr U was to be commissioned by West Berkshire Social Services but following discussions between the police and the director of social services a multiagency review would be convened by the probation service. This did not take place and we have been unable to find out why."

"...the lack of leadership about which agency was to lead on a post-incident multiagency review was and at the time of our investigation remained problematic. The deputy director of governance told us that no arrangements exist should this become an issue again."

We also became aware that there were some tensions between the trust and probation for which we were unable to ascertain the cause.

"We tried several times to meet with the probation officers responsible for the care of Mr T and Mr U but were unsuccessful. We arranged instead to meet with the local area senior manager but the appointment was rearranged once and then cancelled the day before it was due to take place. We sent the local senior probation manager extracts from transcripts of trust managers'

interviews. These related to their view of the probation service involvement in the case and in the post-incident review arrangements. We received a written response.”

“The probation service conducted its own internal investigation, which it declined to share with partner agencies or with us. Trust senior managers told us that the chief executive of West Berkshire Council formally asked the probation service for a copy of its report but it declined.”

(All quotes page 35)

The implementation of this recommendation is noted as completed on 8 December 2014 in the trust’s action plan.

We were provided with a protocol, *Mental health care related serious incidents, suicides & homicides. A local interagency Berkshire-wide approach to the investigation process* (March 2015). The protocol states:

“Where serious incidents, suicides or homicides occur within the field of mental health care they will often be committed by individuals with complex needs, whose ongoing mental health care may/can span multiple providers. This can cause confusion amongst those providers as to who should be required to undertake an investigation and more importantly, which provider will take the lead role in organising a meeting to agree roles and responsibilities and the production of investigation reports.”

“...the trust will take lead responsibility for setting up a meeting to agree the lead organisation for the investigation. The lead organisation, once identified and agreed, will ensure that all partners provide reports combining the timeline and chronology of events leading up to the incident which may span several departments and services and will oversee the production of each services contribution to the overall investigation report and resulting action plan.”

The protocol goes on to say that the need to conduct statutory case reviews (in respect of children, adults and domestic homicide) supersedes this protocol. We looked at an example of such a review relating to a domestic homicide.

The Director of Nursing and Governance confirmed that the six unitary authorities that the trust works with, the police and probation services have all seen it and are in agreement with it. She confirmed that the default position is that the trust will automatically take the lead on setting up a multiagency review unless there is a good reason for another agency to do this and the trust would then cooperate with that lead agency. At the time of writing this report no interagency reviews have been conducted under this protocol but they have been conducted under statutory children’s and adult’s safeguarding and domestic homicide procedures.

In respect of the concerns about interagency working identified by our independent report, the Director of Nursing and Governance told us that:

- at the time of the homicide investigation partnerships did not function well but working relationships have now improved;
- the Community Partnership Board now works effectively – probation, trust and police all sit together; discussions and decisions about reviews take place at the Board
- the relationship with the probation service has improved - the trust and probation now have named contacts and know who to talk to if there are any problems; and
- the trust has a good working relationship with the mental health lead for the police.

6.3.2 Finding

F3 The trust has developed a protocol that governs when a multiagency review should take place. This is not a signed, formal multiagency agreement but senior managers told us that all the statutory agencies were in agreement with it.

6.4 Summary and conclusions

In general there has been a notable improvement in the trust’s understanding and approach to strategic multiagency working and we were told that relationships with key agencies have improved. None of the recommendations relating to interagency agreements have resulted in formal signed multiagency agreements. However, we have been assured that all the agencies are in agreement with the trust’s policies that relate to interagency working.

In respect of this it is worth noting that the *Management of mental health crisis: interagency partnership agreement between Thames Valley Police and health and social care agencies (The mental health crisis care concordat¹)* describes a “list of partner agencies and signatories to protocol - Clinical Commissioning Groups, Mental Health Trusts, NHS Trusts and Foundation Trusts, South Central Ambulance Service, Local Authorities and Thames Valley Police”. We take from this that partner local agencies are able and willing to develop and sign multiagency protocols.

¹ *The Mental health crisis care concordat* is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

7 Recommendations relating to the governance of trust investigations

7.1 The trust should ensure that a person in a direct-line management relationship or in the locality/directorate does not undertake investigations with the service under investigation. An investigation must be conducted by a suitably trained individual who is clear about its role and function. [R7]

This recommendation arose out of our concerns that the trust's serious incident investigation process and subsequent report was inadequate. The trust's managers accepted this.

The trust action plan notes that the implementation of this recommendation was completed on 8 December 2014.

7.1.1 Background from Verita's independent report

"Regardless of the skills or knowledge of the commissioning manager or investigating officer there is a procedural integrity in having any investigation undertaken by a manager who is not in a line management relationship with the service being investigated, or even within the locality service. This is important to rebut any possibility of bias and can be important if, for example, a coroner reviewed the report."

"... it was ... necessary for the trust to conduct a serious incident investigation by a suitably trained member of staff."(Both page 37)

We have reviewed the trust's *Incidents/near misses, serious incidents requiring investigation and coroner requirements - policy & procedures*, October 2015. It is a comprehensive document setting out the policy relating to "the reporting, investigating and management of all incidents and near misses within (the trust)." It states:

"Investigating officers outside the service where the incident has occurred will be appointed... A database of trained and available investigating officers within the trust is maintained by the executive assistant to the director of nursing and governance. When an investigator is needed for a SI (or a complaint or HR investigation) the executive assistant will be asked to obtain an investigator from this list, ensuring that for SI cases the investigator is not from within the operational area where the incident occurred and is suitable for the type of case being investigated."(Section 8.2).

The Deputy Director of Nursing and Governance told us that the process for conducting investigations has changed as a result of Verita's investigation and that no investigations are now conducted by staff from the service that is under investigation.

We were told that 80 investigations have taken place since the Verita review.

We were provided with a copy of a training proposal, from a training provider “In Practice”, for investigating officers and a copy of a *Root cause analysis workbook*¹. We were told that there are 194 trained investigating officers across the trust and, of these, 124 have had the new training as outlined in the training proposal. Further training will be available in December 2015 and all new managers are given training. Investigating officers tend to be on band 8As (senior staff) and above. Less complex investigations are undertaken by more junior staff but the objective is to get the right person to undertake an investigation.

‘Buddies’ are allocated where an investigating officer either needs support or is conducting an investigation in an area that is not their specialty. Buddies are also not part of the service being investigated.

Each locality has a patient safety manager who is responsible for providing support to the investigating officer; clinical directors can also provide support if required. External independent investigators are appointed when required.

We noted that there is no cross reference in the policy to when an interagency reviews (see 6.3 above) should be instigated.

7.1.2 Finding

F4 The trust has assured us that investigating officers no longer undertake investigations in their own services. All investigations are conducted by suitably trained individuals who are clear about their role and function.

7.2 The trust should amend its policy for investigating serious incidents and reporting on them to ensure sufficient challenge and scrutiny are built into the process. The board, including non-executive directors, should receive a full report from all level 5 incidents as well as themed reports. The board should be able to assure itself about the progress of recommendations from all serious incidents. [R9]

This recommendation arose out of concern that there was insufficient board-level scrutiny and challenge in the serious incident investigation process.

7.2.1 Background from Verita’s independent report

“We think the current system for conducting SI investigations contains weaknesses. The lack of involvement by non-executive directors and the fact that investigation reports are not taken to the board seriously hampers the board’s ability to hold the executive to account and to learn lessons from the investigation. Part of the role of the non-executive director is to provide

¹ “Root cause analysis is one method for determining the underlying, as well as the immediate, causes of incidents and events, enabling staff and management to learn from and avoid similar incidents and events in the future”. (Root Cause Analysis – In Practice)

independent challenge, as the Mid Staffordshire Hospital public inquiry has shown.

We accept that a large number of incident reports do not need to be reviewed individually by the board, but the board and non-executive directors should always review reports on investigations of (serious) incidents, as required by the trust's 2013 policy on serious incidents.

Not requiring the investigating officer to present findings to the Patient Safety Review Group meeting seriously reduces the level of scrutiny that the report is subject to. In these circumstances, the investigating officer loses accountability and challenge for their investigation and cannot explain and face questions about their findings and recommendations. We think the process for implementing and monitoring recommendations from investigations is not robust and that the board must have a means of monitoring progress on the implementation of recommendations.”(Page 41)

The trust's action plan notes that the implementation of this recommendation was completed on 14 October 2014. The trust added an additional action in this section “To ensure staff are aware of their safeguarding responsibilities and actions they must take”: this was noted as completed on 9 February 2015.

The trust's *“Incidents/near misses, serious incidents requiring investigation and coroner requirements (October 2015) comprehensively sets out policy and procedures. It describes the responsibilities of various groups and committees as follows.*

Trust Board. For effective implementation of this policy, there must be active support from the most senior members of the trust. Therefore the Chief Executive and board receive a monthly report on the SIs that have occurred in the previous month as well as quarterly report on the lesson learnt. They also gain assurance through the activities and minutes of the relevant groups and committees as detailed in the trust governance structure. Serious incidents... will be reported to and overseen by the board and returned to the board for scrutiny when completed.

Quality Executive. The quality executive is responsible for receiving the quarterly incident/SI [serious incident] report for the organisation. They will scrutinise the contents; ensure that any action plans surrounding the report have been implemented; and ensure learning has been shared throughout the organisation.

Locality Patient Safety and Quality Groups. The locality groups will receive a monthly summary of all their incidents with key themes and lessons learnt. They are responsible for ensuring that local action plans have been developed and implemented.

Patient Safety Review Group. This group is responsible for reviewing all SIRIs [serious incidents requiring investigation] ensuring that investigations have been carried out accurately and that action plans have been developed

and implemented. This is where SI reports have formal executive sign off for being submitted to commissioners and any appropriate external agencies.”(Pages 10 and 11)

The locality patient safety and quality groups and Patient Safety Review Group report to the Quality Executive. This reports to the Quality Assurance Committee that reports to the trust board.

In our interview with the Deputy Director of Nursing and Governance she told us that:

- board-level panels now oversee the whole serious incident investigation process;
- the Director of Nursing and Governance is responsible for taking reports to the board and this includes all serious incident reports;
- the board has a process for following up on the implementation of recommendations;
- the chairman is part of the oversight panel for serious incidents (homicide and suicide) investigations;
- the initial draft report is taken to a locality panel where the investigating officer presents their report and the service responds;
- the report is then taken to the Patient Safety Review Group which involves the Director of Nursing and Governance and the Medical Director. It is chaired by the Deputy Director of Nursing and Governance. The report is only signed off following discussion with the investigation officer;
- there is a CCG Review Meeting attended by trust senior managers to discuss reports; and
- face-to-face meetings are offered to families throughout and they get a copy of final report.

One of our concerns in our report was the lack of involvement of non-executive directors (NED) in the investigation process. The Director of Nursing and Governance told us that the Chairman of the trust, in his role as chair of the Board Oversight Panel, undertakes a scrutiny role. The NED who has responsibility for quality chairs the Quality Assurance Sub-committee of the board and, of course, NEDs sit on the trust board where reports are taken.

The Deputy Director of Nursing and Governance assured us that the process is robust.

We were shown examples of serious incident review reports that have been taken to the board.

7.2.2 Finding

F5 The trust has established a robust process for ensuring that sufficient board-level scrutiny and challenge is built into the investigation process.

7.3 Summary and conclusions

Since our investigation the trust has introduced new policies and procedures that have ensured that investigating officers are suitably trained and do not investigate incidents in their own service area. The training is comprehensive and a central list of investigating officers is available. The Deputy Director of Nursing and Governance manages the list. Support and advice is available for staff undertaking investigations.

The trust has also introduced new policies and procedures, which ensure that there is sufficient board-level scrutiny and challenge built into the investigation process. Three internal groups have been established which assist the board in carrying out its responsibilities.

The trust should be commended on its robust approach to investigating serious incidents.

8 Recommendations relating to operational issues

8.1 The trust should ensure that the work of the short-term team is integrated into the secondary mental health services and its function is clearly understood. [R1]

This recommendation came out of concerns that the short-term team was a 'stand alone' team, with no medical input, providing social care to service users who were not subject to the Care Programme Approach (CPA).

8.1.1 Background from Verita's independent report

"The short-term team is a social care team dealing with people who do not meet CPA criteria. This is an unusual model, though not necessarily a wrong model. However, access to psychiatric support appears to have been ad hoc.

"The trust provides mental health services to those not on CPA (through the short-term team) but we have seen no guidance or policies relating to criteria for providing services to those who do not fit CPA criteria."

"We were told ... that (the team) did not provide care co-ordination in a formal CPA way."

"The structure of the service and the pathway for service-users is unclear, with users being potentially dealt with by a number of teams. We have seen no documentation describing how these teams relate to each other. In particular, how the role of the short-term team fits with other teams." (Pages 20 and 21)

The trust's action plan states that the implementation of this recommendation was completed on 9 February 2015 but action was taken sometime before to ensure the team no longer carried out "unidisciplinary triage and allocation; allocations now go through multi-disciplinary team". The action plan shows in some detail how implementation was achieved.

The *Care pathways operational manual*¹ for West Berkshire describes how the "... Care Pathways Team (CMHT) is the local multidisciplinary and multi agency team providing services within West Berkshire."

¹ A care pathway is an outline of the anticipated care and services for a patient with a specific condition or set of symptoms as they progress through their treatment

According to the West Berkshire CMHT structure chart, the CMHT is made up of:

- The short-term team;
- West Patch Multi-Disciplinary Team (including Early Intervention Team¹ for the whole of West Berkshire);
- East Patch Multi-Disciplinary Team (including the Assertive Outreach Team for the whole of West Berkshire); and
- Psychology.

Sitting outside of this structure are:

- Common Point of Entry Team (CPE)²;
- Crisis Resolution and Home Treatment Team (CRHTT)³; and
- Inpatient services.

According to the care pathways manual, the short-term team takes referrals from the CPE, Urgent Care (CRHTT and in-patients) and the local authority:

“The short-term team is the first point of contact for all referrals, they will screen the referral for accuracy and completeness of information as well as considering the immediacy of the response required and the initial level of support required.”

The Head of Mental Health for West Berkshire told us that referrals come direct from the CPE which has input from psychiatrists (provided by the various patch teams). The CPE determines which of the teams is best placed to meet the needs of the service user. The teams for onward referral are CRHTT, the east or west patch teams and the short-term team. If the user is known to one of the patch teams or there is an immediate need the referral would automatically go to that team.

The care pathways manual states:

“People who enter Pathways will have an agreed care plan, risk management plan and a named care coordinator who will work collaboratively with the person to meet their needs, address risks and achieve goals ... People will either have ‘standard care’ status or, when there are increasingly levels of complexity or greater risk, they will qualify for ‘Care Programme Approach’ (CPA) status.”

The Head of Mental Health also told us that the short-term team is fully integrated with the CMHT and that it essentially has a preventive function. However, its users are not subject to CPA and will not have complex needs. (We assume here that they have ‘standard care’ status as described above.)

¹Early intervention in psychosis teams offer assessment and treatment to those experiencing symptoms of psychosis for the first time.

² The Common Point of Entry team provides a short, focused assessment at the point of referral to identify the best service for the clients’ needs.

³ The Crisis Resolution and Home Treatment Team provides intensive short-term care in the community for people in acute distress.

We were told that the local authority is in favour of this model of service delivery.

The short-term team has a role in triaging referrals from CPE or elsewhere to identify the most appropriate care pathway.

“...the short-term team will gather information in order to present to the MDT referrals allocation meeting. In this meeting team leads and medics from across the service discuss the needs of the service user and the onward pathway that can best meet the service user’s needs.”

We were told that the short-term team consists of local authority social workers and NHS occupational therapists and that a nurse was about to join the team. It has 10 members of staff.

The care pathways manual states:

“In terms of providing intervention, the Short Term Team are able to work in a Recovery focused way, providing short term (6-12 weeks), intensive interventions with the aim of increasing independence and overcoming practical and emotional difficulties:

- Working with individuals to be as independent as possible
- Supporting people to make their own choices
- Helping people to develop their own skills in daily living
- Being flexible with people to meet their needs
- Offering a solution focused approach in order to achieve identified goals
- Developing strategies to overcome obstacles in people’s lives
- Increasing self-esteem and confidence.”

The short-term team is also responsible for providing the Approved Mental Health Professional ¹(AMHP) function for the patch. The Head of Mental Health told us that six of the 10 staff are AMHPs and each member of staff holds an average of five cases with the occupational therapists also running two groups. There are an additional two AMHPs (making eight in total) in the patch teams.

In 2013/14 130 Mental Health Act assessments were carried out which roughly equates to 11 a month or 1.3 assessments for each AMHP a month.

The team also provides a duty service:

“Duty is a resource for people to be able to access help and support throughout the week from a Healthcare Professionals, it is manned Monday to Friday 9am to 5pm, this is additional support for people for anyone under the care of the CMHT when their health care professionals is not available or if they feel they require additional support”. (Head of Mental Health)

¹ An Approved Mental Health Professional is a person who is warranted, or authorised, to make certain legal decisions and applications under the Mental Health Act 1983. Usually, this person will be a social worker who has undertaken additional training to become warranted but in 2007 the law was amended to allow other mental health professionals to undertake this role. Psychiatric nurses, occupational therapists or psychologists can also act as AMHPs.

Comment

As we said in our previous report this is an unusual model but not necessarily a wrong one. Our concerns then were that the team functioned independently of the rest of the service, there was no medical input and its brief was not clearly understood. The *Care pathways operational manual* states what interventions the short-term team provides, including the AMHP function and that it now has medical input.

However, we remain unclear about the team's role in respect of managing inward referrals as part of the care pathway. We also found the overall care pathways structure somewhat confusing and we were left wondering whether service users felt the same. We asked the trust for clarification on a number of points¹ but still are left with a number of questions about the team's role.

- Whether the team's role in respect of initial assessment and allocation is effective?
- Whether the trust, as a provider of secondary mental health care, should be providing services to users not subject to CPA?
- What links the team has with primary care services, and in particular Improving Access to Psychological Therapies²?
- Whether there are any allocation criteria for the team?
- Whether the team is, or should be, undertaking risk assessments?
- Whether there is a risk of users undergoing multiple assessments by the CPE, the short-term team and the west and east patch teams

In the final stages of this review, the trust responded that, although the short term team is an integrated team with health and social care staff, the team is funded by the local authority. In addition, the trust has been informed that the local authority is currently reviewing the way in which Adult Social Care works in line with their responsibilities under the Care Act 2014. This review impacts upon the way in which the CMHT & therefore short team work, as the proposal is for Social Workers to be aligned to Local Authority localities and to no longer work in an integrated way with health. As such, the future of the short term team is dependent on the local authority and not the trust.

At present, we are unclear when this local authority review will be completed.

8.1.2 Finding

F6 The short-term team is now integrated into the overall team structure and has medical input. The team provides a range of social interventions, the AMHP service and a duty service. However, we still have some concerns about its role and function.

¹ Emails to trust

² Improving Access to Psychological Therapies is an NHS programme offering psychological interventions for common mental health conditions such as depression.

F7 We found the care pathway structure difficult to understand.

F8 The Local Authority, which fund the short term team, are conducting a major review of all services which will include the short term team. The trust is awaiting information the outcome of this review.

8.1.3 Recommendations

R2 The trust should clarify the role and function of the short-term team following the local authority review.

R3 The trust should review the *Care pathways operational manual* to ensure that the care pathway structure can easily be understood.

8.2 The trust should issue a practice guidance note reminding all staff that a referral for a psychiatric assessment should always be made if requested. If a referral is not to be made a recorded rationale for why must be placed on the patient's notes. [R3]

This recommendation came out of concerns that a referral for a psychiatric assessment was not followed through.

8.2.1 Background from Verita' independent report

The "assessment plan said a referral to a psychiatrist should be made, but Mr T was referred to the short-term team so the referral to the psychiatrist was redundant because his needs had been assessed as mainly social."

"The failure to refer Mr T to a psychiatrist meant that an opportunity for a formal mental health assessment was lost."

"Mr T's history and previous contact with the trust meant that a second opinion from a psychiatrist should have been obtained."(All quotes page 16)

The implementation of this recommendation is noted as completed on 6 August 2014 in the trust's action plan.

We were given a copy of the good practice note that states:

"Psychiatric Referral - When Common Point of Entry recommend a referral for a psychiatric opinion, this must happen unless a multi-disciplinary team decide that a referral is no longer required. The reasons for this decision must be detailed in the patient notes. It is the responsibility of any professional involved with patients to ensure their individual care plan is implemented."

The action plan also notes that this was communicated to staff via a screensaver, which appeared on all staff computer screens. The Director of Nursing and

Governance received assurance that the message had been disseminated to all staff. She told us that this action had been recorded as being completed in subsequent serious incident investigations.

8.2.2 Finding

F9 The trust has issued a practice guidance note reminding all staff that a referral for a psychiatric assessment should always be made if requested.

8.3 The trust should develop and implement a strategy for improving record keeping. [R8]

This recommendation arose out of concern that the trust had not implemented two recommendations of its own internal inquiry relating to improving record keeping.

8.3.1 Background from our report

“The (trust’s) internal report made two recommendations which were about record keeping. The trust told us it accepted that record keeping was generally poor. The trust said one of the reasons for this was a lack of literacy in the workforce. However, we saw no examples of poor literacy in the records. Some of the recording was poor but literacy did not appear to be the problem. The trust senior management team told us they had made improvements in patient record keeping and were improving community record keeping with an audit.”

“The trust appears not to have a strategy for improving record keeping.” (Both quotes page 40)

The trust action plan notes that the implementation of this recommendation was completed on 8 December 2014.

We were given two documents:

- The trust’s *Clinical records strategy* (October 2015)
- *Clinical record keeping project update* (undated), which includes an action plan.

The strategy describes the vision for the trust:

- “One multi-disciplinary record for each patient.
- The right records in the right place, at the right time for the right patient.
- The Rio system is an integrated electronic patient record, and electronic health record, for use across the whole Trust.”

The strategy sets out how the trust will develop and implement policies and procedures in records management, and how it will set standards and monitor performance and accountability.

The action plan sets out three key areas for implementation with designated leads:

- raising awareness of the importance of record keeping;
- reinforcement of good practice (including training requirements); and
- providing assurance (through audit).

The Director of Nursing and Governance told us that the strategy is being led by one of the clinical directors. Reports to the Quality Executive Group show CMHTs are showing evidence of improvement and a marked improvement is being seen in urgent services. A target has been set of 80%, but this is a 'high standard' and needs to be seen in context. For example, audits showed that one locality had a significant improvement from 23% to 55% in meeting the standards, but still required further improvement.

8.3.2 Finding

F10 The trust has a comprehensive strategy and action plan for improving record keeping. There are signs of significant improvement but this needs to be seen in the context of the trust starting from a low base.

8.4 Summary and conclusions

The trust has developed a comprehensive strategy and action plan for improving record keeping. A good practice note in respect of referral for psychiatric opinion has been developed.

9 Conclusion

There has been improvement in the trust's working relationships with its statutory partners and, according to the trust, they are now on a more robust footing. However, some policies that relate to interagency working are not interagency policies per se.

The trust has introduced robust policies and procedures in respect of serious incident investigations with several levels of scrutiny up to, and including, the trust board. Investigating officers are properly trained, there are sufficient numbers and they do not investigate cases in their own service area. The trust should be commended for its approach.

The trust has developed and is in the process of implementing a clinical records improvement strategy.

The work of the short-term team is integrated into the wider care pathways model and it has medical input. To this extent the trust has implemented the recommendation of Verita's report. However, we did identify some concerns about the work of the team and have included these in our report for the trust's consideration. We also found the care pathway structure difficult to understand.

The trust has implemented the recommendations of the Verita investigation report.

Documents reviewed

- Action plans in response to Verita independent investigation report
- Notes of an interagency professionals meeting
- *Care pathways operational manual* (West Berkshire)
- Emails from Verita to Head of Mental Health (West Berkshire)
- *Management of mental health crisis: interagency agreement between Thames Valley Police and health and social care agencies*
- *Psychiatric referral good practice note*
- Email in respect of *Psychiatric referral good practice note*
- Letter to Thames Valley Police from the trust's Chief Executive, 4 March 2015
- Letter to the trust Chief Executive from Thames Valley Police, 27 March 2015
- Quality Executive Group minutes 8 June 2015
- Emails in respect of MAPPA
- *Mental health care related serious incidents, suicides & homicides. A local interagency Berkshire-wide approach to the investigation process*, March 2015
- *Incidents/near misses, serious incidents requiring investigation and coroner requirements – policies & procedures*, October 2015
- SIRI training proposal
- Copy of a communication from NHS England that complemented senior trust staff on their approach to meeting with a family member to discuss the Verita report and the trust's action plan
- *Root cause analysis workbook*
- *Clinical records strategy*, October 2015
- *Clinical records strategy update and action plan* (undated)
- *Risk assessment and management in mental health and learning disability services*
- Front cover of two board reports in respect of Verita's independent Investigation
- Two board reports on serious Incidents Investigations

Appendix B

Staff Interviewed

- Director of Nursing and Governance
- Deputy Director of Nursing and Governance
- Head of Mental Health (West Berkshire)