Sussex Partnership NHS Foundation Trust Assurance Statement

An independent investigation into the care and treatment of a mental health service user Mr K in Sussex.

Publication date. 29th January 2020.

This independent investigation was completed by Niche Health and Social Care Consulting on behalf of NHS England (Homicide Investigations).

The Serious Incident:

On 8 September 2014 Mr K seriously assaulted his neighbour by stabbing them multiple times with a knife. He was subsequently arrested for attempted murder, charged and sentenced to life in prison. At the time of the serious incident Mr K was under the care of Sussex Partnership NHS Foundation Trust.

As the serious incident occurred in September 2014, NHS England has requested that the Trust provides an Assurance Statement outlining the improvements undertaken by both the team that provided Mr K's care and the Trust since the incident.

The independent investigation identified 8 recommendations for the Trust.

Recommendation 1

The Trust must ensure that when the terms of a client's criminal justice/probation licence to be in the community make reference to compliance with a treatment programme; clinical teams are clear about what actions could result in a breach of the terms, and how these should be reported. This will enable teams to report potential breaches appropriately.

Actins undertaken by the Trust to support meeting this recommendation:-

- In line with NHS England's requirements, the Forensic Outreach and Liaison Service Operational Policy has been reviewed and rewritten to ensure it reflects national guidance as well as encompassing the recommendations from this independent investigation.
- When a referral is received for Forensic Outreach and Liaison Service input a decision will be made if the interventions required meet the criteria for Care Programme Approach or Risk Reduction pathway. At this point, joint working agreements are made which include the minimum requirements in relation to information sharing.
- A copy of the licence requirements is forwarded to the team prior to release from prison and is uploaded onto Carenotes. This is to ensure all staff are aware of the licence requirements which are then incorporated into the 'My Shared Pathway' care plan which includes details of what to do in the event of a breach of licence.
- If a breach of licence the following happens;
    - Review of the care plan which includes a review of the risk assessment and crisis plan.
    - Contact with probation to discuss (as per care plan)
    - Recorded on carenotes (electronic care record)
- Formal structures are in place to review all client/patients on the caseload which includes;

    - Weekly Forensic Outreach and Liaison Service Team meeting which includes the notes of the meeting being shared with all meeting attendees during the meeting; signed off , stored in an secure electronic file and uploaded onto Carenotes.
    - A review of all client/patients who have not attended / disengaged which includes zoning as red or amber depending on risks.
    - As part of the Forensic Outreach and Liaison Service Team meeting the zoning procedure is followed. In addition, zoning rating can only be reduced when reviewed by 2 professionals. However zoning can be increased by 1 professional. This is communicated to the team through our electronic records system and within team meetings.
    - Discussion in regards to zoning is recorded on Carenotes, therefore available for all staff.
- As part of the Forensic Outreach and Liaison Service weekly meeting, if a client/patient consecutively does not attend three times (or sooner if risks indicate) a Forensic Outreach and Liaison Service 'Did Not Attend (DNA)' action plan is triggered and an multi- disciplinary review is held where the current clinical /risks are reviewed , to determine appropriate action. This could potentially include a Mental Health Act assessment. The discussion, outcome and management plan is recorded on Carenotes and Care Programme Approach documentation updated as appropriate. If known to other agencies, those other agencies will also be informed of 'DNA' status, in particular probation to ensure licence conditions are not breached.
- All legal (Mental Health Act) and licence requirements are included in the care plan. This requirement has been supported by a presentation to staff. Quarterly notes audit is in place with the results fed back to the Community Leadership Team to action.
- Forensic Outreach and Liaison Service has a weekly reflective practice meeting where patients of concern can be raised. Each staff member receives clinical and management supervision as per Trust supervision policy requirements. Supervision compliance is monitored through central reporting on My Learning with monthly compliance figures published which includes the names of staff. In addition, supervision compliance is monitored through Community Leadership Team operational structure.
- The Forensic Outreach and Liaison Service weekly team meeting forms part of the Forensic Health Care senior management structure.
- With the client/patient's permission, Probation is invited to attend the relevant part of the Care Programme Approach (CPA) review.
- The Probation service hold the licence as part of Offender Management and complete their own risk assessment (called OASYS) which is shared with the Trust and uploaded onto Carenotes.
- DNA / Non–engagement work stream has commenced in Forensic Outreach and Liaison Service. Supervision notes include discussions and any concerns will be raised. Non engagement workshops continue to be developed and will be signed off by Community Leadership Team.

Recommendation 2

The Trust must ensure that the operational policy for the community forensic service provides clarity about which risk assessments are required when working with a client under the 'Risk Reduction' pathway of the policy.

Actions undertaken by the Trust to support meeting this recommendation:-

- For all service users under the care of Forensic Outreach and Liaison Service, the minimum requirement is the completion of the generic Trust risk assessment as outlined in the Clinical Risk Assessment and Safety Planning / Risk Management Policy and Procedure. The FOLS operational policy reflects this requirement and is in line with the Trust's Clinical Risk Assessment policy.

- Clarity is provided within the Forensic Outreach and Liaison Service operational policy that when a person is on the Risk Reduction pathway then another external service provider takes the lead.
- A separate working group has been set up to look at the Forensic Outreach and Liaison Service risk reduction work stream with the outcome of this reporting into the Forensic Healthcare Care Delivery Service which will monitor the progress, implementation and outcome.
- In relation to the Risk Reduction Pathway, all actions agreed within the Forensic Outreach and Liaison Service team meeting are clearly documented within the minutes. This is followed up during the weekly meeting.
- As identified under Level 2 of the service model for Forensic Outreach and Liaison Service, Risk Advice Forums (RAF) have been set up for Sussex Partnership staff to gain access to specialist advice in relation to risk reduction options.
- In the Forensic Outreach and Liaison Service operational policy, the parameters of risk reduction are clearly defined – including when care coordination is required. This is to ensure roles and responsibilities are very clear for all practitioners.
- As above, weekly team meeting with senior staff in attendance are in place.
- Overall governance of the care is reviewed by the team within the weekly Forensic Outreach and Liaison Service meeting. This is supported by individual supervision which includes reviewing the practitioner's caseload. In addition, the clinical records system, Carenotes provides a dashboard which details the lead practitioner's current compliance with risk assessments and care plans. This is further supported by the quarterly clinical records audit.

Recommendation 3

The Trust must ensure that when the 'Risk Reduction' pathway is being used to manage a client's care and treatment, the service has a clear plan of the intended outcome of the pathway, so that the therapeutic interventions intended to reduce the client's risks are clear and how the outcomes are measured and monitored is also clear.

Actions undertaken by the Trust to support meeting this recommendation:-

- The Forensic Outreach and Liaison Service operational policy now clearly outlines the Risk Reduction pathway and when this is the sole focus of the intervention, the aim is to provide this for a time-limited period. This includes specifying the interventions the Mental Health Team will provide as well as naming the lead agency.
- Once the work has been completed under the Risk Reduction pathway, the client/patient is discharged from the Forensic Outreach and Liaison Service.
- If a client/patient is initially seen by Forensic Outreach and Liaison Service on the Risk Reduction pathway but on further assessment, their care needs require greater intervention, care can be stepped up if required. This is managed through the multi-disciplinary team review and discussions within the Forensic Outreach and Liaison Service team meeting. This will include the client/patient.

Recommendation 4

The Trust must ensure that there is clarity about when clients should and should not be subject to Care Programme Approach and that individual operational policies do not contradict the Care Programme Approach policy.

Actions undertaken by the Trust to support meeting this recommendation:-

- In the development of the Forensic Outreach and Liaison Service operational policy, to ensure consistency, the formal Care Programme Approach policy has been cross referenced.
- Within the Forensic Outreach and Liaison Service operational policy, when a patient meets the Care Programme Approach criteria it states that the team will follow the guidance as documented within the Trust CPA policy
- All client/patients under the care of the Forensic Outreach and Liaison Service, receive a formal clinical review every 3 months and Care Programme Approach review every 6 months.

Recommendation 5

The Trust must ensure that when a client is allocated to clinicians working in separate teams, a clear plan is in place to manage how communication will be managed between those clinicians and what action should be taken by whom if any issues need to be escalated.

Actions undertaken by the Trust to support meeting this recommendation:-

- Every client/patient is discussed at a minimum of once a month which can be increased to weekly if concerns are raised. Therefore, if clinicians are working in different teams, the notes of the meeting are available within the secure electronic file and through Carenotes, the electronic clinical record system. Client/patients on the Risk Reduction pathway are usually discussed each week and a summary/update given and recorded on the team meeting minutes.
- In addition, as part of the Care Programme Approach Review, different members of the team, regardless of location, are invited to attend. This is completed at the team meeting. The Forensic Outreach and Liaison Service have a robust tracker which is used to ensure discussions occur. In addition, within the meeting, if concerns are noted, the Lead Practitioner is immediately informed and this action is documented as part of the meeting.

Recommendation 6

The Trust must ensure that when a care coordinator is not at work for extended periods of time, appropriate plans are in place for the clients on his or her caseload to receive suitable support.

Action undertaken by the Trust to support meeting this recommendation:-

- The Forensic Outreach and Liaison Service have developed and appointed to the new role of Team Leader whose role includes overseeing sickness/absence.
- If a key member of staff is not present for the clinical review meeting, the update can be found on the Tracker which is available to all staff on a secure B drive.
- The administration team initially manage unplanned staff absences by checking the diary which is held electronically which all can access. The Team Leader will then re-allocate visits / meeting as clinically required. The Team Leader will also monitor to ensure required visits are completed. If the period of sickness is likely to be lengthy, the Team Leader reviews the practitioner's caseload and will allocate the on-going care accordingly.
- As outlined in the Forensic Outreach and Liaison Service Operational Policy, if leave is unplanned, the role of re-allocation is the responsibility of the Team Leader; if the leave is planned then the Lead Practitioner as part of their usual duties is expected to ensure all required clinical contacts are allocated during their leave.
- When a client/patient is discharged from hospital/ released from prison, there is a minimum of 3 clinicians appointed as the core team and this will remain in place for at least 6 months. This is

to ensure continuity of care and in the event of unplanned leave, a clinician who knowns the client/patient can provide cover.

Recommendation 7

The Trust must ensure that the new guidance for documenting MAPPA discussions is included in the appropriate policy.

Action undertaken by the Trust to support meeting this recommendation:-

- Within the Forensic Outreach and Liaison Service policy an explanation of Multi-Agency Public Protection Arrangements (MAPPA) is included which also provides advice as to how to record a meeting.
- The revised Clinical Risk Assessment contains a section on MAPPA, thereby ensuring all SPFT clinicians who may come into contact with the client/patient are made aware of the management under MAPPA.
- For any client/patient on MAPPA, the service has a responsibility to inform MAPPA of any increased risk or change of address or recall to hospital.
- The team have good links with the Social Worker Professional Lead (Forensic) who is available for advice and guidance.
- For people on Level 3 MAPPA, the Professional Lead for Social Work within the CDS is involved.
- For each MAPPA Level 2 and 3 meeting, a Forensic representative attends. **N.B MAPPA level 1 is a reporting requirement with a database form completed and as a consequence there is no meeting to discuss Level 1 MAPPA cases.**

Recommendation 8

The Trust must implement a system to ensure that structured feedback is provided to all clinicians involved in the care and treatment of a client when there has been a serious incident investigation.

Actions undertaken by the Trust to support meeting this recommendation:-

- All recommendations made in Serious Incident Investigations are shared and regularly reviewed within the Care Delivery Service (CDS) leadership team.
- The Forensic Healthcare Leadership has a clear Governance process in place.
- The implementation of action plans and the evidence to support the completion of this is actively monitored through the Governance Team. This includes monthly updates on all outstanding actions.
- All investigation reports and recommendations are discussed with the team at training events such as Community Continual Professional Development Day. They are also discussed individually with staff involved. Reflective practice, de-brief sessions and support is also offered to staff.
- Supervision is in place for all staff which includes learning from serious incidents. Compliance with supervision is monitored at Team, CDS and Trustwide level.
- The Trust has a number of ways it shares and embeds learning across the Trust such as:-
    - Patient Safety Matters which is a regular bulletin sharing learning from SIs supported by local and national evidence.
    - Learning events which focus on a theme, such as collaborative risk assessment and safeguarding with the events supported by the Patient Safety Matters.

- The Trust has implemented an Incident Dashboard so anybody with a Trust log-in can review anonymised incidents and serious incidents pertinent to their team and other teams in the Trust.
- Confidential internal briefings are utilised to share any immediate learning from serious incidents.
- The Trust has facilitated a number of conferences, the latter one being 'Learning from Serious Incidents'.
- Four times a year, the Trust publishes the Quarterly Quality and Safety Report.