An independent thematic review of investigations into the care and treatment provided to service users who committed a homicide and to a victim of homicide by Sussex Partnership NHS Foundation Trust. Prepared by Caring Solutions (UK) Ltd

Volume 1: Main report

An independent thematic review of investigations into the care and treatment provided to service users who committed a homicide and to a victim of homicide by Sussex Partnership NHS Foundation Trust: Volume 1 Main Report

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Contents

1. Introduction

Structure of the report

1.1 This report is in two volumes. This, Volume 1, is the main report and contains sufficient information for us to address the Terms of Reference satisfactorily. Volume 2 contains supporting evidence and supplementary information, which provides more detail on the key findings presented here.

1.2 The report is presented in three main sections:
   i. introduction and background to the review
   ii. findings: benchmarking data, thematic review, adverse event indicators, implementation of the action plans; and review of the Trust's Board Assurance and governance systems
   iii. recommendations.

Background information

1.3 In 2014/15 the Sussex Partnership NHS Foundation Trust (hereafter referred to as the Trust) saw 51,560 patients and admitted some 3,255 of them as inpatients (either voluntarily or compulsorily) representing 6.3 percent of those seen. Nationally, 1,835,996 people were seen by all NHS mental health services, of whom 103,844 were admitted, a rate of 5.7 percent. The admission rate can be as high as 15 percent in Camden and Islington NHSFT.

1.4 In the Trust some 21,325 people were accepted on to the Care Programme Approach (CPA) which represents 41.4 percent of those seen while the national average is 18.3 percent and the rate varies between 1.5 percent in Gateshead Health NHSFT and 44.3 percent in South Staffordshire and Shropshire Health NHSFT.

1.5 Between 2010 and 2015, eight of the Trust's service users committed homicide, one in a different police area. In the Sussex Police area, 52 homicides (including those committed by Trust service users in Sussex) were recorded between 2010/11 and 2014/15.

1.6 The police in England and Wales recorded 4,876 homicides between 2007/08 and 2014/15. Two hundred and ninety-seven people who were convicted of homicide between 2007 and 2013 were found have been mental health service users or former users.

1.7 When a person commits homicide who was at the time, or in the preceding six months, a service user of an NHS mental health trust, there must be an independent investigation of their care and treatment. NHS England is responsible for commissioning these investigations but the investigations are carried out independently of the NHS.

1.8 These investigation reports conclude with recommendations for improvements to the service. The trust then creates an action plan, setting out how and when they will complete actions to implement the recommendations. Implementation of the actions is monitored by the Trust.

The Clinical Commissioning Group also has a role in assuring that action plans are carried out.

1.9   Before an independent investigation takes place, the mental health trust will have carried out its own internal inquiry by a team of people who had no direct responsibility for the care and treatment provided to the person who committed the homicide.

1.10   It is very important to recognise that the Trust has not remained static over the past eight or nine years. The Trust has been through a series of structural reforms that have materially changed the organisational design and orientation. Towards the end of 2007, there was a growing recognition that the duplication of services in three localities whilst cultivating local identity was not an efficient way to manage services and resulted in inconsistencies and services being delivered to different standards.

1.11   The structure of the services and allocation of clinical responsibilities have undergone further major change in orders to improve the care delivered to service users. These major changes took place in 2011/2012.

1.12   Most recently, in order to devolve more decision making closer to where patients are treated, the Trust created nine Care Delivery Services (CDSs). Four of these relate to adult mental health services and cover four geographical areas: Brighton and Hove, Coastal West Sussex, East Sussex and North West Sussex. The remaining CDSs relate to Care Home services; Children and Young People; Forensic Healthcare; Learning Disabilities; Primary Care and Wellbeing.

The Review

1.13   NHS England and the Trust jointly commissioned Caring Solutions (UK) Ltd to carry out an independent thematic review of the care and treatment of patients known to Sussex Partnership services who committed a homicide. These homicides took place between 2010 and 2015 or where the investigation process concluded within that time. The brief also involved reviewing the case of an inpatient who was the victim of homicide while under the Trust's care.

1.14   The aim is to scrutinise the Trust's response to these incidents in order to provide assurance to the public, patients and carers, commissioners, the Board of Directors and Council of Governors that learning has been embedded within the organisation.

1.15   The Executive Director of Nursing and Quality and Executive Medical Director for the Trust and the Head of Investigations (South East) for NHS England sponsored the review.

1.16   The Trust asked Caring Solutions (UK) Ltd to include a carer on the review team. We did include a carer as a member of the expert panel. We have provided full details of the review team in Volume 2, Appendix A.

1.17   The review team carried out a number of benchmarking exercises and reviewed and identified themes from 11 reports.

1.18   This is a review of reports of 11 investigations into the care and treatment provided by the Trust to ten service users who became involved in serious incidents. These incidents took place between 2007 and 2015.   There are two types of report, and two types of serious incident included in this review. The following diagram shows the number of reports and number of incidents in each category. The number of serious incidents is shown in brackets, following the number of reports.

Table 1: The number and type of reports and incidents.

	Independent reports	Internal reports	Total
Homicides	8 (7)	2 (2)	10 (9)
Victim of homicide.	0 (0)	1 (1)	1 (1)
Total	8 (7)	3 (3)	11 (10)

1.19   This table shows that there were:
- ten serious incidents (two reports related to one serious incident)
- nine serious incidents (10 reports) are homicides[1]
- one service user was the victim of a homicide
- eight of the homicide investigations were independent (relating to seven homicides)
- two of the homicide investigations were internal.

1.20   Five of these serious incidents were committed by service users who were receiving care in Brighton and Hove, three by service users who were receiving care in East Sussex and two by service users who were receiving care in West Sussex.

1.21   Full details of the methodology and the reports are in Volume 2, Appendix C. NHS England has published all but one of the independent reports (publication pending). These are available at:

https://www.england.nhs.uk/south/publications/ind-invest-reports/

1.22   The table which follows (Table 2) shows when each of the service users came into contact with the Trust and how long they remained service users.

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[1] Homicide is the killing of one human being by another. The cases included in this review were offences of murder: offences of manslaughter on the grounds of diminished responsibility.

Table 2. Length of time the service users were in contact with the Trust.

Service user	2007				2008				2009				2010				2011				2012				2013				2014				2015			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Case 1				■																																
Case 2						■	■	■	■	■	■	■																								
Case 3					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			
Case 4											■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■				
Case 5														■	■																					
Case 6															■											■	■									
Case 7																	■	■																		
Case 8																						■	■	■												
Case 9																					■	■	■													
Case 10																																	■			

Note: Not all of the cases span complete quarter years but this schema gives an idea of the period of time each of these service users was in contact with services. This schema also demonstrates the problem of linking care and treatment to particular events in the organisation of care.

2.   Benchmarking

2.1   This thematic review covers 10 incidents of homicide which occurred between December 2007 and July 2015 (nine of which were committed by people known to Sussex Partnership NHS Foundation Trust and one where the victim was known to services). All of the homicides were committed in the community as opposed to on Trust premises. None of the perpetrators were detained under Mental Health Act at the time, although one was an informal inpatient who was absent without leave.

2.2   Homicide covers the offences of murder, manslaughter and infanticide. This thematic review covers nine homicides which took place between 2010 and 2015.

2.3   The homicide rate involving people known to Sussex Partnership NHS Foundation Trust is not disproportionately high compared to other areas of the country. That said, every such incident is a tragedy which has devastating consequences for the families affected.

2.4   The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015) states that in recent years around one patient homicide on average occurs annually for every million of the general population. This allows a crude calculation of the potential number of patient homicides in the Trust.

2.5   The Trust covers a population of 1.6 million. According to NCISH's analysis, this would equate to eight homicides committed by someone known to mental health services over the five-year period covered by the thematic review (as is the case).

2.6   The thematic review examined cases in the last five years (2010 – 2015) where a homicide occurred involving someone known to Sussex Partnership services or where the independent investigation process concluded in this time period. The rationale for this was that it would be difficult to extract and apply new learning from historical cases (i.e. longer than five years ago) given that services provided by Sussex Partnership have changed so significantly in recent years.

2.7   In this five-year period, eight incidents occurred where the perpetrator was known to Sussex Partnership services and one incident where the victim was known. One of the cases covered by the thematic review dates back to 2007 because the independent investigation process did not conclude until much later. In one additional case, the victim of the homicide was known to Sussex Partnership, bringing the total number of cases covered by this review to 10.

2.8   When compared with the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) cohort and other data sources, Trust patients were:

- Exclusively male (about 15 percent of the NCISH cohort are female).

- Older than the national figures would suggest as four out of the nine perpetrators were aged '45 or more' whereas nationally the '25 to 44' age group is most numerous.
- 'White British' – there is no comparable national data but local samples tend to show greater ethnic diversity.
- Five out of the nine killed an 'acquaintance', two killed family members. This is also true nationally although family members and current and former spouses and partners follow closely when combined.
- Only two of the homicides involved a stranger who had no previous relationship or knowledge of the perpetrator. Nationally, patient homicides where the victim is a stranger have been falling over recent years.
- Five of the nine used sharp instruments while the remaining four used their fists or feet. The means of killing reflect the impulsive nature of the majority of the killings. This finding mirrors the picture for England.

2.9   The NCISH research suggests three indicators of likely breakdown are: (i) failure to take medication; (ii) failure to attend appointments; and (iii) the misuse of drugs and alcohol. While about half of the national cohort (49 percent) were either noncompliant or missed their last appointment and some 89 percent misused drugs and alcohol:

- None of the Trust cases seem to have been non-compliant with medication.
- Three of the Trust service users seem to have missed their last appointment though there is some ambiguity in one case where the service user missed their last appointment with their care coordinator five weeks prior to the homicide but attended a clinic for depot medication two days before the incident.
- Two of the Trust service users had no known record of drug and/or alcohol abuse. The remaining seven all had histories of a long and, in several cases, varied history of drug misuse. In four cases, the service users admitted to misusing both alcohol and drugs. Two admitted misusing a single drug – cannabis in one case and 'legal highs' in the other. Two of the seven admitted using 'legal highs' at some time.

2.10   Nearly half of the Trust cases had been in long-term contact with mental health services (i.e. 10 years or more) over their lifetimes. They may not have been in contact exclusively with the Trust (or its predecessors) for all of that time but several had been in more or less continuous contact while others had been in and out of contact with services as they moved around the country. Only one service user had been in very short-term contact – less than one month with the remainder in contact for more than three months but less than two years. Three of the service users had initially come into contact with mental health initially as children or teenagers.

2.11   The national figures suggest that service users who commit homicide have either been in touch with services recently (i.e. 'in the last seven days') or some time ago (i.e. 'over 13 weeks ago') - a U-shaped curve of contacts. It is not possible to tell how many members of the national cohort had been

formally discharged from services back to primary care and how many had simply stopped attending and had been discharged as 'Did Not Attend'.

Conclusions

2.12   The number of patient homicides each year is low and the number committed by Trust service users fluctuated over the period. The rate of homicides by Trust service users was lower than that found in some comparable size mental health trusts but higher than in others.

2.13   Trust patient homicides were unusual in that they were all committed by male patients who were exclusively 'white British'. They tended to kill acquaintances rather than family members, spouses or complete strangers. They tended to use sharp bladed instruments, which reflect the impulsive nature of their offences.

2.14   Many of the service users who committed homicide were misused drugs but they tended to comply with their appointments and their prescribed medication. In this sense, they did not conform to the usual risk indicators found in the study of national trends in patient homicide.

3. Recurring Themes

3.1   As a rough rule of thumb we have included themes if they occur in at least two of the investigation reports. One of the problems with drawing out themes is that the reports refer to a long period of time. The first homicide took place in 2007 and the last in 2015 while the organisation of services changed considerably in 2011/12. Some of the themes may have occurred before the reorganisation but we believe that some represent attitudes and ways of thinking which are independent of how services are organised at any one point in time. The structural changes did not involve wholesale changes in staff, the existing staff moved to new roles and some may have taken former ways of working with them.

Escalating service users to a proper level of expertise

3.2   Several of the cases considered here highlight the problem of arranging access to services quickly while the service user is motivated to address their mental illness. In some cases, there is a delay in the initial contact and in others the delays occur once contact has been made with mental health services when assessments by specialist services are required.

3.3   Service users present at their GPs' surgeries with complex sets of symptoms: the GP then refers them to mental health services. Many are quickly given appointments for assessment but sometimes there are delays which cannot later be explained. Unless there is an immediate risk of harm to self or others, there will inevitably be a delay until an appointment is available. The problem is making sure that the initial assessment made by the mental health service is both speedy and accurate. It is a problem of

triaging the service users with complex needs, who are a risk to themselves and/or others, and getting them through the system as quickly as possible and then to specialist assessors. The realities of the pressure of workloads mean that while staff do their best to work according to Trust policies and procedures while the lives of some mental health service users go on at their own speed towards an eventual incident.

3.4   These comments have been made against a background of organisational change which has been described elsewhere. The new structures are designed to speed up the process of getting service users to the right level of care. Services have been improved for those with personality disorder. Access times to psychological support, substance misuse services and forensic services have improved. The current waiting times for assessment by Neurobehavioural and Neurodevelopmental specialist services are known to be lengthy and this is being addressed with NHS England at a national specialist commissioning level.

Risk assessment and risk management

3.5   Risk assessment is important in that it allows higher risk cases to be given higher priority in terms of staff time and, in some cases, the use of a multi-agency approach. There is also the assumption that staff would have to be more cautious in their management of the case if the people involved have a clear assessment of the risk of violence posed by the service user.

3.6   In seven out of the nine homicide cases there was some criticism of the risk assessment process and/or the design of a risk management plan. The level of criticism varies but in several cases, the process was seen as inadequate and the risk posed by the service user went unrecognised or was severely underestimated.

3.7   Criticisms of risk assessment and risk management fall into the following areas: initial assessments, not collecting and integrating information (including information from family members), not using specialist knowledge when it is available, not following trust policies on domestic violence and vulnerable adults, and risk management plans including relapse strategies.

Knowledge of and use of Mental Health Act

3.8   Several of these cases raise the question of Trust staffs' knowledge of the Mental Health Acts and related legislation. On several occasions, Trust staff did not know the full extent of their legal powers when working with service users.

Systemic or professional problems identified

3.9   Several of the investigations reported that one or more aspects of practice did not conform to local policies and/or to national guidelines:

- A 'Think Family' approach was rarely, if ever, followed to the extent that none of the carers in these cases had been identified in a legal sense as carers and their rights and needs were never assessed (Care Act, 2014). Similarly, policies on domestic abuse and safeguarding were not always followed.
- The NICE guidelines suggesting that those with signs of psychosis should be referred to psychological services did not seem to have been followed in all cases (see NICE guidance CG178 2014, section 1.3.4 Treatment Options).
- NICE guidelines also suggest the use of Occupational Therapy but not all the service users here had been referred (NICE guidance CG178, 2014).
- Several of the service users might have had a dual diagnosis i.e. both a mental illness and a substance misuse problem. However, this was not identified (see NICE Pathway, Psychosis with coexisting substance misuse overview).

3.10   Greater emphasis on recovery was thought to be needed by investigators. There appeared to be a lack of evidence that service users in long-term contact were subject to longitudinal assessments in the sense that they could remain on caseloads for several years without a critical review and a fundamental re-examination of the service user's presentation.

Conclusions

3.11   A number of recurring themes were found in the investigation reports. It was clear that in a number of these cases there were problems in getting the service user to the appropriate level of care and treatment while they were motivated to change. In some cases, there were unexplained delays in making appointments, but in others, the assessment process did not happen quickly enough to match the deterioration in the service user's mental state.

3.12   Several of the investigations found that risk assessment and risk management were inadequate. In some cases, risk assessments were not completed or they did not use information from family and carers effectively. Sometimes the member of staff making the risk assessment did not understand the risk implications of the service user's criminal record.

3.13   Some of the Trust's staff did not understand the extent of their powers under the Mental Health Act when working with service users.

3.14   In some of the cases, staff did not follow local policies and/or national guidelines in areas such as domestic violence, the safeguarding of vulnerable people, or the provision of psychological or other support for service users and their carers.

4.   Emerging themes

4.1   The ten investigation reports (including the manslaughter victim case) were analysed for themes using a 'Safety Framework' (following Vincent, 2010).

The factors contributing, in varying degrees, to the homicide or other event fall under the following headings:

- Patient factors
- Individual (staff) factors
- Task & technology factors
- Communication factors
- Team factors
- Working environment factors
- Organisational & management factors
- Institutional context factors

4.2 At the top of the framework are patient factors. This is because the service user's condition will have the most direct influence on practice and outcome. Other service user factors such as personality, language and psychological problems may also be important as they can influence communication with staff. The design of the task, the availability and utility of protocols and test results may influence the care process and affect the quality of care. Individual (staff) factors include the knowledge, skills and experience of each member of staff, which will obviously affect their clinical practice. Each member of staff is part of a team within the inpatient or community unit, and part of the wider organisation of the hospital, primary care, or mental health service. The way in which an individual practises and their impact on the patient is constrained and influenced by other members of the team and the way they communicate support and supervise each other. The team, in turn, is influenced by management actions and by decisions made at a higher level in the organisation. These include policies for the use of locum or agency staff, continuing education, training and supervision and the availability of equipment and supplies. The organisation itself is affected by the institutional context, including financial constraints, external regulatory bodies and the broader economic and political climate.

4.3 Table 3 below shows how the contributory factors were distributed across the cases. As might be expected Patient & Team factors feature in all the cases. Task & Technology and Communications factors are the next most frequent category (each is mentioned in eight cases). Individual (staff) factors were mentioned in seven cases. The Work Environment and Organisational & Management factors were mentioned in two cases. Institutional context factors were not found to be present in any of the cases.

Table 3 Distribution of contributory factors across the cases

Contributory factors	Number of times mentioned in Trust cases
Patient factors	10
Team factors	10
Task & Technology factors	8
Communication factors	8
Individual (staff) factors	7
Work Environment factors	4

Organisational & Management factors	4
Institutional Context factors	0
Total number of factors mentioned	51

4.4   These results reflect the difficult problems posed by this sample of Trust service users whose personalities, lifestyles and characteristics were complex with long-established patterns of erratic behaviour. They were described as 'guarded and mistrustful' of services, lacking insight into their condition, with long histories (often denied) of polydrug and alcohol misuse. Some of these service users were skilled and controlled what healthcare professionals knew about them while one had previously exaggerated the level of risk posed in order to be admitted as an inpatient.

4.5   Not all of these factors were of equal levels of concern and the seriousness of many seems to have changed as a result of organisational changes within the Trust. For example, one of the early investigation reports criticised a team for failing to record contacts properly while in later reports the criticism had changed to be one of a lack of detail being recorded as to the rationale for decision-making.

Conclusions

4.6   The Safety Framework provided a way of drawing together the wide range of issues which were seen as contributing to the patient homicides. Patient factors were the most frequently occurring which coincides with the observation that many of the service users had long histories of concealing their attitudes and behaviour from mental health staff. The various factors were found to present in nearly all of the cases and some (for example, individual staff and team factors point in the direction of persistent patterns of established working practices which do not always comply with best practice.

5   The 'mind-set' of policies

5.1   Some Trust policies seem to be written from the perspective of the service user as a victim rather than as a perpetrator. This tendency occurs in several places. For example, the purpose of the Trust's policy on Domestic and Sexual Abuse is to 'ensure that both service users and staff who have experienced domestic and sexual abuse in the past or present are supported safely and appropriately'.

5.2   The policy describes specific objectives which include giving staff a framework for 'assessing and appropriately responding to disclosures of domestic and sexual abuse by service users and carers' and 'incorporating assessment for domestic and sexual abuse into the risk assessment of all service users'. This sentence is liable to be read in the context of the service users being vulnerable and liable to exploitation when it should be read in the opposite way. This alternative approach to assessment should be included alongside the Trust's risk assessment processes.

5.3   In their discussion of clinical staff's 'duty of care' when there is domestic or sexual abuse, the main import of the duty is in respect of the service user, while potential victims of service users are not mentioned.

5.4   The Trust's policy on Incident Reporting sees the safety of service users, staff and the environment as of paramount importance. It is clear from these investigation reports that some incidents of violence and aggression that occur in the community are not reported through the Serious Incident system. It is not clear that similar incidents occurring in a ward would be treated in this way. Violence in the community may also be an indicator of violence towards Trust staff.

5.5   These comments are not saying that service users may not be vulnerable people and indeed many are and their needs should be recognised and ways found to alleviate their suffering. However, some service users may be perpetrators of violence, exploitation and abuse, and Trust policies should reflect that reality and in the process alert staff to a more questioning approach. A more questioning approach may lead to better and more accurate risk assessments and more effective risk management plans, some of which will involve multiple agencies.

Conclusions

5.6   The Trust's policies should encourage staff to take a questioning, critical stance towards service users' behaviour, or at least, they should be even handed when staff are considering the possibility that the service user could be a perpetrator of violence rather than a victim. The latter is more likely to be the case but not invariably.

6   Adverse Event Indicators

6.1   The Terms of Reference for this thematic review included identification of any 'adverse event indicators' which are generally seen as instances which indicate or may indicate that a patient has received poor quality care. As we did not review the original case records, we are not in a position to comment on the quality of care these individuals received. We did, however, see the investigation reports, which allow us to comment on what others saw as good or poor quality care.

6.2   Many, but not all, independent investigations of patient homicides are asked, or set themselves, the question of deciding whether the homicide was either predictable or preventable, or both. In seven out of the nine Trust patient homicides, the investigating panels explicitly address these questions. Different investigators tend to have their own definitions of predictability and preventability (some more explicitly spelt out than others).

6.3   In one case, the panel concluded that the homicide was predictable. Importantly, they restrict their comments to the knowledge that professionals have rather than the knowledge available to family members and carers. In one further case, an investigation panel concluded that the homicide was

preventable because the service user was not effectively managed by the healthcare team; they were thought not have assessed the level of risk posed properly and if the service user had been assessed as high risk then a management plan would have been triggered. In the panel's view, there was known evidence of risk factors. In the remaining six cases of patient homicide, the panels did not believe the homicide was preventable.

6.4   These comments emphasise once again the importance of good risk assessment which is both comprehensive in terms of drawing together all the relevant information and then coming to a sound formulation, not once but every time the service user's circumstances change. It is open to speculation whether these homicides could have been prevented.

7   Recommendations made in independent homicide investigations

7.1   This section of the report concentrates on the recommendations made by the independent investigations of homicides and sets out the areas where independent panels thought improvement was needed. Usually, but not always, recommendations are linked to the contributory factors that were identified. Often the connection is not as immediate as investigators may opt to recommend wider, more widely encompassing, recommendations which will deal with more than one of the factors they believe contributed to failings in care and treatment. Investigation panels may also make recommendations which have several parts so that a single recommendation might include three or four bullet points**.**

7.2   The analysis of recommendations leads to an analysis of how far and how effectively the Trust has turned these recommendations into action plans and then how effectively the action plans have been translated into organisational or practice change. Normally, there should be signs in later reports that issues raised in earlier reports have been implemented and the issues do not recur. In this instance, there is the problem that the three HASCAS reports were not only carried out some time after the events they investigated but they were published without the Trust being informed of their existence in their final form. As described above the Trust had made considerable changes in its organisation independently of these investigations.

7.3   The recommendations are disparate but they have been categorised using a set of ideas created by Niche Patient Safety.   The eight Trust independent investigation reports (seven homicides) produced 48 recommendations.

Table 4: Frequency of recommendations made

Topic of recommendation	Frequency of mentions	
	Trust cases	Niche cases
Communication	3	19
Policy Management	4	13
Practice/risk	22	13

Training	4	9
Organizational (sic) learning	8	8
Contact with families	5	5
Miscellaneous	1	1
Pathway development	1	1
Total recommendations made	48	78

7.4   The Niche figures come from nine homicide investigations their company carried out between 2014 and 2015 (this total includes one Trust patient).

7.5   In Table 4, the largest single category of recommendations relates to 'Practice/Risk', 22 mentions out of 48. This category includes recommendations on the need for risk management and care plans, that the Trust should assure itself that inpatients are not detained illegally and that the Trust should assure itself that all staff understand the criteria and use of sections 2 and 3 of the Mental Health Act. Many of these recommendations can be seen as investigation panels asking the Trust to make sure that its existing policies and procedures are being completed on a systematic basis, every day, with every service user.

7.6   The next largest category is that of 'Organizational Learning' which includes recommendations such as suggesting that the Trust should audit all new processes for effectiveness within six months of the publication of the report or that the Trust should conduct an audit in conjunction with Primary Care (now Clinical Commissioning Groups) stakeholders to ascertain the timeliness of referral processes and should revise pathways, if necessary, in the light of the findings.

7.7   'Contact with families' is the third most frequent category of recommendations in the reports we reviewed. Recommendations in this category include a Trust-wide panel developing a reliable method for systematically and comprehensively involving family members when screening for risk and that the Trust Board should consider signing up to the 'Triangle of care' or a similar approach to involving families, significant others and carers:

7.8   'Policy management' includes recommendations about the Trust examining all clinical policies and procedures to ensure that NICE guidance is embedded within them particularly in respect of substance misuse and Personality Disorder or that the Trust must revise all policy documentation in the light of the findings of the Investigation report and all policy documentation should be subject to review and audit for both compliance and effectiveness as part of the Trust's audit cycle:

7.9   The 'Training' category includes recommendations that the Trust should ensure that all medical staff receive sufficient support from colleagues and peers, reflective practice should be embedded into the supervision process, and that the Trust will audit its revised CPA processes within six months and the audit will be devised in conjunction with the relevant (CCGs).

7.10   'Communication' includes a recommendation that the Trust will ensure that professional communication and liaison processes are built into all care pathways and all clinical policy and procedure documents, or that the final outcome of contact with secondary mental health services should always be communicated to the service users' GP. The CCG and Trust should agree on the routes of communication between secondary mental health services and GPs, and embed these into practice.

7.11   The 'Miscellaneous' category includes the recommendation that the 'Trust would agree how and when a new integrated community and ward IT system will be introduced...'

7.12   A number of studies (see Volume 2, Appendix D) have produced an historical survey of recommendations made over a period of twenty or so years that demonstrate a remarkably high degree of continuity. Many of the recommendations made here and elsewhere require Trusts to audit practice to ensure that everyone is complying with Trust policies and procedures but few spell out precisely what is being asked for and many do not set timescales against which Trust performance could be assessed though this is changing with the new NHS England approach to independent investigations.

7.13   The usual prescription in the face of staff inadequately assessing service users' needs or to assess the level of risk they pose and then to formulate a risk management strategy complete with indicators of breakdown and the means of spotting and avoiding breakdown is recommendations for more training. However, many of the aspects of practice that are being complained as of poor or variable quality are already part of initial training and in-service professional development. The implication seems to be that training in its current shape does not do what is expected of it.

Conclusions

7.14   A 48 recommendations were made in the homicide investigation reports. The majority can be categorised as relating to 'Practice/risk' which is not surprising given the findings of the emerging issues and recurring themes sections of this report. This category was concerned with getting the basic activities of care and treatment right so that staff knew what type of service user they were caring for and what risk they presented. Investigators also wanted the Trust to learn as an organisation from its activities – to be able to distinguish between the effective and the ineffective.

7.15   Contact with families is of increasing importance whether it relates to information collection for risk assessments or whether it is providing support for families and carers throughout the service user's illness or when things go wrong.

7.16   Changes to training and communications are less frequently mentioned but they do still continue to be recommended. One of the recommendations on

training was in respect of CPA, which has been the fundamental building stone of care and treatment for over two decades.

7.17   These recommendations stand in a long tradition of such recommendations. A number of historical studies of investigation reports, published from 2000 onwards, have shown very similar results. Investigation reports dating back to the 1990s also refer to CPA, risk assessments, the lack of work with families and so on.

8   Implementation of Action Plans

8.1   We requested evidence that recommendations and action plans had been implemented. We wished to fully assure ourselves and, by extension, the Trust, NHS England and the general reader. In most cases, we, therefore, required more than confirmation by the Trust that an action had been implemented. We needed to see the evidence. For example, the Trust might confirm that there is a policy, or that training has been delivered, but we needed to see the policy or details of the training or the number of people who have attended. The exception was where the action and evidence referred to named individuals.

8.2   We assessed the evidence provided according to the three NHSLA levels, described in Volume 2, Appendix C - Methodology. We have separately recorded where the Trust has confirmed implementation but not provided supporting evidence, and where no information was given. There are a small number of 'other' outcomes.

8.3   The Table below summarises and analyses the information which the Trust provided.

Table 5. Implementation of recommendations and action plans.

Evidence provided	Assessment of evidence provided
Policy evidence provided (Level 1)	21
Practice evidence provided (Level 2)	20
Performance evidence provided (Level 3)	38
Evidence not requested, confidentiality	3
Implementation in progress	6
Other	12
Total number of recommendations/actions	100

8.4   The investigations generated a sizeable number of action points in total (100). The Trust provided evidence of a level of implementation in the great majority of the actions, including evidence that over one-third of actions were being embedded within the organisation.

8.5   Some actions related to named individuals so we did not seek to see the evidence and there is a small number of actions where there is either no information or the action has not yet been commenced.

8.6   We assessed that action points were, in the main, SMART. The earlier action plans may have been less so. More recent plans were also very clear as to who (or what role) held lead responsibility, with specific deadlines for completion and a note of the evidence which the Trust had determined would demonstrate completion.

8.7   The first observation which we can make is that, although relating to incidents spread over a number of years, there are a relatively large number of separate actions (100). In addition, actions arise from less serious incidents and from complaints. This number raises the question for us whether it is reasonable to expect this (or any other) mental health Trust to implement all actions/recommendations fully and to be able to provide supporting evidence of that implementation.

8.8   There was some repetition in the action plans. For example, several recommendations related to care planning and implementation; several related to risk assessment and management; several related to non-involvement of families and carers. In these cases, this suggests that, over the period and homicides reviewed, the Trust had not fully implemented changes in practice across all their services.

8.9   The great majority of action points accurately reflected the recommendations. Action plan authors appeared to have misinterpreted only one action. In one further report, the plan author distinguished between 'the Trust' (responsible for a general outline of a process) and 'local services' (responsible for operational detail).

Conclusions

8.10   The Trust has demonstrated that some 80 percent of the identified actions had been implemented. In over one-third of cases, the Trust had demonstrated that learning was being embedded across the organisation, through the audit and re-audit of practice.

8.12   We made several request requests to collect the supporting evidence which would demonstrate that actions had been implemented. We were concerned that this indicated that the Trust's administrative systems were not fully fit for the purpose of demonstrating learning from investigations into homicides and other serious incidents. We recognise that these investigations reported over a number of years during which organisational structures and administrative procedures have changed, making it more difficult to retrieve information. We understand that, in light of this experience, the Trust has introduced new methods for linking actions with evidence electronically – this will make it easier in the future for the Trust or those it commissions to review learning to access the necessary evidence. We have now seen an action plan, which uses this electronic linkage.

8.13   We recognise and fully support the principle of delegating responsibility to clinical directors and service managers, to enable local services to develop and have ownership of service and care delivery improvements. However, the Board of Directors retains overall responsibility for the care and treatment provided and for reducing the risk of similar incidents occurring in the future.

8.14   One recurrent theme clusters around involving carers and families. Some of the action plans report that the Trust is committed to implementing the Triangle of Care, and has provided evidence of progress towards this goal. The 'Triangle of Care' is a 'therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains well-being' (http://static.carers.org/files/caretriangle-web-5250.pdf). We wished to make explicit the steps, which are involved in the strategic and operational implementation of the Triangle of Care. These are:

- Strategic buy into carer matters:
  o Presence of a carer engagement strategy and its ownership by the Board and senior management
  o Strategic leadership for carer matters
  o Ownership of carer interests at all levels
  o Staff promotion of carer initiatives
  o Commissioners giving clear directives on carer engagement
  o Evidence of joint working between the Trust, CCG and Local Authority on carer matters.

- Implementation process including:
  o Implementation lead for the Trust carer strategy
  o Carer champions in departments
  o Guidelines for sharing information with carers
  o Carer information sources are available
  o Carer awareness training to all staff.

- Board assurance and monitoring, evidenced by:
  o Director level, Governor and Non-Executive monitoring of carer work
  o Trust quality account
  o Board papers
  o Trust annual reports
  o Monitoring committee for carers' charter and strategy - implementation
  o PALS - reporting of carer issues including complaints and actions taken.

8.15   Finally, we noted that many of the action plans focus on processes – for example revising a policy, providing training. We consider that a focus on the outcomes and on changing practice would increase the likelihood that learning will be embedded. Furthermore, we conclude that monitoring the impact of these changes on stakeholders including service users, carers and staff would reinforce improvements in practice.

9 Board assurance, governance and embedding learning

Processes and systems

9.1 The documentation and all sources of information reviewed for this section of the report are listed in detail in the Methodology section, (Volume 2, Appendix C).

9.2 This section is based first on a review of the Trust's assurance processes as they are now. The Trust has developed and refined its systems over the period of this review. We did not review systems which the Trust has replaced. Second, we reviewed some examples of these processes and systems to understand how they work in practice. We reviewed only those policies and guidance which relate to serious incidents, primarily homicides.

9.3 One of the policies provided to us was out-of-date, in terms of both the local and national structures and the local systems it describes. In some instances, (for example, domestic violence) the Trust was slow in developing policy at the local level that had been introduced by central government. Trust committees had not approved one of the policies that were provided. The Trust makes the point that the constant internal and external change means in practice that, by the time a policy has been reviewed and revised, it can be out-of-date before it is approved and the Trust has to go back to the beginning of the process.

9.4 The existence of word processing and the intranet should be used to provide interim versions of policies to help staff navigate changing policy environments. Interim policies can carry a 'health' warning but staff would at least have some working guidance.

9.5 The policies and guidance we reviewed covered:
• risk management – all aspects of risk, including clinical risk, across the Trust
• reporting serious incidents
• 'Being Open' and the Duty of Candour.

9.6 These policies included information on how the Trust would monitor compliance and the evidence that would be required.

The reporting and monitoring structure in practice

9.7 We reviewed the working of these processes and how systems work in practice.

9.8 In February 2016, there was a report on implementing requirements from the CQC inspection in January 2014. The report identified one relevant requirement:
• The Trust and the local service must improve the effectiveness of the links between the corporate and local governance processes.

The Trust assessed its progress towards achieving this requirement as 'Amber' in February 2016 and continues to monitor progress towards compliance.

9.9   We noted that Clinical Directors take an active role in the reporting structure, thereby providing a 'bridge' between the Board of Directors and the Care Delivery Services (CDSs). However, given the relative newness of the current Board reporting structure, of the CDS organisational structure and of the recent appointment of Clinical Directors it may be too early to assess the effectiveness or otherwise of this link.

9.10   As part of their approach to improving communication with front line staff, the Trust is developing a 'Policy on a Page' model which disseminates policies to them in an easy to digest format.

9.11   The 'Report & Learn' bulletin is emailed to all staff and put on ward/office notice boards. The CDSs are encouraged to use these bulletins as a basis for discussion on how to change practice in staff meetings.

9.12   In relation to incidents, the Board Assurance Framework report for January 2016 notes 'variable reporting of incidents in CDSs' as a 'gap in assurance'. The minutes of discussion of this agenda item are brief, but one action was agreed, namely to develop a strategy of evidence-based pathways to go to the May meeting of the Board.

9.13   In January 2016, the Trust-wide Dashboard reported on the percentage of Serious Incident reviews which were completed and submitted within the required 60 days. Only 48 percent of reviews were completed on time and this was rated 'red'.

9.14   In adult services, it was reported that good processes were in place in the governance arrangement for CDSs to share learning from Serious Incidents. The North West Sussex CDS held a successful 'Report & Learn' event including service user leaders and local partners.

9.15   Some of the areas for improvement in care and service delivery which have been identified elsewhere in this report also appeared in the Board Assurance and Governance systems and processes. From a variety of sources, these areas for improvement include:
   • failure to follow procedures
   • records not updated
   • lack of communication
   • inadequate communication with relatives
   • risk assessments not taking into account the full history of the service user
   • concerns that clinical risk assessment and observation policies were not followed
   • documentation was not always of the standard required
   • communication within the multi-disciplinary team.

9.16   This indicates that perhaps not unsurprisingly, some of the themes identified in relation to the homicides are not peculiar to homicides. Similar themes have occurred in the care of service users involved in other serious incidents. More pertinently, these events were happening between 1 October and 31 December 2015 – which indicates that those changes are not happening consistently across the Trust in practice, despite the recommendations and action points identified in the previous section.

9.17   The introduction of a web-based system for the entire process of incident management from reporting an incident through to monitoring the implementation of action plans appears to be presented as a potential solution to some of the issues around action planning, implementing and monitoring. However, experience suggests that IT systems may not be a complete solution to human behaviour problems.

Conclusions

9.18   The Trust has established clear lines of accountability and responsibility for investigating, reporting and learning from homicides and other serious incidents. There are clear processes for monitoring all aspects of the entire procedure – from reporting incidents to embedding learning.

9.19   These processes are in line with the requirements of NHS England's 'Serious Incident Framework' (2015).

9.20   The evidence shows that Board assurance processes identify where the Trust is implementing actions and making improvements. The processes are also effective in identifying areas for improvement in service and care delivery. This evidence is recent and reflects the themes identified in previous sections of this review. It is positive that their processes are identifying where service improvements are required: the Board must retain a clear focus on ensuring that actions based on investigation recommendations are fully implemented across all Care Delivery Services and that evidence of that implementation can be provided.

10. Recommendations

10.1 Throughout this review, we have noted a tendency in mental health homicide investigation recommendations and Trust action plans to focus on processes and activities (for example, re-writing policies, providing training).

10.2 In order to improve the quality of care and treatment provided by this and other mental health mental health trusts, and to reduce the likelihood of similar incidents recurring, we consider that the focus should move towards outcomes, changes in clinical practice (for example, on the completion of risk assessments across the Trust for all clients) and the impact of practice on stakeholders, including service users, healthcare professionals and support staff, and the broader public.

10.3 The recommendations below are designed to support NHS organisations to provide this focus and to facilitate more outcome and impact based practice in the investigation (internal or independent) process.

10.4 The recommendations below are listed in order of priority.

Recommendations for the Trust

10.5 The Trust and its Board of Directors are asked to consider implementing the following:

i. The Board of Directors should monitor the implementation of the CDS structure and the use of the Safeguard Serious Incident recording system (Ulysses) to assure itself that investigation management and implementation of action plans are consistent with Trust policies, processes and systems.

ii. The Board of Directors should build upon the work already in place to assure themselves, their stakeholders and the wider public that learning from all recommendations is being fully embedded across the organisation in a timely manner. Currently and in the future, where there is Level 1 evidence, the Board should be expecting the Trust to move towards Level 2 compliance with recommendations; and likewise, where there is Level 2 evidence the expectation of Level 3 evidence should be made clear. If these are not appropriate, then the Trust should be transparent as to the reasons.

iii. The Board of Directors should assure themselves that there are robust systems in place to provide evidence that actions have been implemented in a timely manner and in line with the requirements of each action plan.

iv. The Trust should ensure that clinical staff have dedicated time for recording notes and record keeping; that staff record the rationale for the clinical decisions they make and use risk assessment and formulation to inform relapse planning.

v. The Trust should investigate the feasibility of technological solutions to make it easier to complete records and improve productivity. This might include the

use of voice recognition technology when recording on the electronic record system.

vi.   The Trust should consider developing a checklist of key requirements, based on the themes identified in this report, to be used at all CPA reviews.

vii.   When the Trust evaluates training and education, they should evaluate not only the learner experience but also the impact of the training, using a model such as Kirkpatrick:

      a. Level 1: Reaction (Staff enjoyed and engaged in the training)
      b. Level 2: Learning (Staff acquired the intended knowledge, skills and commitment from the training)
      c. Level 3: Behaviour (Staff apply what they learned back in the workplace)
      d. Level 4: Results (Achievement of organisational targets or goals as a result of the training).

viii.   The Trust should continue to act on its commitment to implementing the 'Triangle of Care' approach to involving carers in the care and treatment of service users. The Trust should aim to achieve membership of the national programme within 12 months.

Recommendations for the CCG

10.6   The CCG is asked to consider implementing the following recommendations:

i.   The CCG should commission services which explicitly ensure that clinical staff complete fundamental tasks, such as recording, implementing the CPA, including risk assessment and management.

ii.   The CCG should specify that providers carry out audits of quality rather simply using electronic systems to count the number of times things are done.

iii. The CCG should specify that providers carry out patient safety auditing of basic practice – e.g. recording, assessments, risk management planning.

Recommendations for NHS England

10.7   NHS England is asked to consider implementing the following recommendations:

i.   NHS England should require independent investigation teams to aim to produce not more than three high-impact key recommendations; if in exceptional circumstances, the team considers that additional recommendations are absolutely necessary; these should be listed in order of priority for improving the service/reducing the likelihood of recurrence.

ii.   NHS England should either:

      a. require independent investigators to use nationally standardised criteria when deciding whether a homicide was predictable or preventable or

      b.   consider removing the requirement to consider predictability and preventability from the core terms of reference, on the grounds that this incompatible with the 'learning lessons' ethos of the Serious Incident Framework (2015) and the principles of Root Cause Analysis.

iii.   NHS England should consider requiring investigation teams to focus recommendations on outcomes rather than processes when the Serious Incident Framework is next revised.

iv.   NHS England should direct investigation teams to focus recommendations on supporting staff to change behaviour and practice (for example, through supervision, performance management, coaching techniques, using a solutions-focussed approach to managing people and developing the organisation).

v.   NHS England should commission independent investigation teams to evaluate the impact of organisational learning when they review the implementation of action plans at six months, at the same time as focussing on whether or not actions have been completed.

Appendix A. Terms of reference

Terms of Reference

There were seven terms of reference:

1) The purpose of this thematic review is to establish whether there are service related themes / wider issues or links recurring across the range of mental health homicides.

2) This process should focus on emerging themes and not the reinvestigation of individual incidents or an examination of Trust policies and procedures unless these are directly pertinent to the review.

3) The review should identify whether all learning from these incidents has been identified and that all required changes to practice have been embedded in the organisation.

4) The review should identify whether the organisation's Quality Assurance Framework provides effective reporting and monitoring of serious incidents in line with the NHS England Serious Incident Framework Supporting learning to prevent recurrence) and subsequent policy and organisational development.

5) The outcome may include recommendations for the Trust and Clinical Commissioning Groups (CCGs), over and above those identified in the individual serious incident investigation reports, with the expectation that the Trust's response to any recommendation is fed back to the group.

6) There should be external clinical and carer involvement in the thematic review.

7) The review should provide advice to the relevant CCGs about mental health commissioning, data management and analysis.

There will be four elements to the work -

1) **Thematic review**

   Review of every independent investigation following a mental health homicide from 2011- January 2016. The aim of this element is to ensure that processes are in place to review the action plans and ensure lessons have been learnt from them.

2) **Benchmarking data**
   To provide a contextual view, key benchmarking data items will be used to compare mental health homicides rates of people in receipt of services from Sussex Partnership NHS Foundation Trust with similar mental health trusts (in terms of size and number of patients treated). Following this it will be possible to identify whether Sussex Partnership NHS Foundation Trust incident reporting is in keeping with best practice within other mental health trusts.

3) Adverse events indicators

This information will be used to identify common themes and trends and any common contributory factors. Information about patterns in these incidents may help to identify key indicators of risk for predictable and preventable homicides. Such information will be summarised to inform the Trust of any key policy, organisational and/or training development requirements.

4) Further Learning

To make recommendations about what further actions are required going forward to address any identified gaps from board to ward.

Outputs

There will be four outputs from the project –

1) A report identifying any service related themes/ wider issues or links that are apparent from the thematic review.

2) A report that establishes whether learning from independent investigations has been implemented and identifies any gaps in that learning, and steps that are being taken to address those gaps.

3) A report that identifies any good practice or areas for development in relation to the organisations quality assurance framework.

4) A set of recommendations for the Trust, NHS England and/or CCG, (over and above those identified in the individual serious incident investigation reports), and guidance regarding the actions necessary to complete those recommendations.

Appendix B: References

Books and articles

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HASCAS (a) *Independent Investigation into the Care and Treatment Provided to Mr X by the Sussex Partnership NHS Foundation Trust.*
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Trust Policies and Guidance

Being Open Policy v 1 (Policy number 109/clinical) Ratified by Professional Practice Forum 11 November 2010 (review date November 2013)

Being Open Policy (including Duty of Candour) v 3 (Policy number 175/clinical) Ratified by Professional Practice Forum 26 April 2015 (review date November 2016)

Board of Directors 24 February 2016 *Public papers*

Board of Directors 30 March 2016 *Public papers*

Clinical risk assessment and safety planning risk management policy and procedure

Identifying and Responding to Domestic and Sexual Abuse v 5 (Policy number clinical 17) ratified by Clinical Policy Forum 22 December 2015 (review date October 2017)

Incident & Serious Incident Reporting Policy & Procedure v 2 (Policy number Risk, Health & Safety 073) Ratified 30 December 2014 by Professional Practice Forum (review date July 2015)

Incident & Serious Incident Reporting Policy & Procedure v 3 (Policy number 067/Risk) Ratified 20 October 2015 by Professional Practice Forum (review date October 2017)

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Risk Management Strategy and Policy v 1 (Policy number 062/risk) Ratified 4 January 2013 (review date December 2013)

Risk Management Strategy and Policy v 1 (Policy number xxx/Risk) Ratifying Committee – the Professional Practice Forum, undated (review date January 2017)

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