VERITA

INQUIRIES – INVESTIGATIONS – REVIEWS

REPORT OF THE REVIEW OF MENTAL HEALTH SERVICES IN THE SURREY HAMPSHIRE BORDERS AREA IN RELATION TO THE CARE AND TREATMENT OF AB, CD AND EF

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1. Introduction

The initials of individual patients, their children and relatives and the victims in these three tragic cases have been changed to protect their anonymity.

1.1. On 23 August 2001 AB, a 20 year old woman fatally stabbed a 39 year old man, GH. AB was subsequently convicted of murder and sentenced to life imprisonment.

1.2. On 2 November 2001 CD, a woman aged 43 years set fire to her family home, resulting in her death and the death of her mother the following day.

1.3. On 11 April 2002, EF a man then aged 31 years killed IJ, his girlfriend. He was convicted of manslaughter and detained under Sections 37/41 of the Mental Health Act 1983, from 10 March 2003.

1.4. During this period in 2001 and 2002 the Surrey Hampshire Borders NHS Trust had also been implementing the recommendations of an earlier Independent Inquiry Report, published in July 2001, into the Care and Treatment of ML, PH and CM, all patients of the local mental health services, who had committed homicides in 1996, 1997 and 1998. All three individuals had received care and treatment from services managed by the Surrey Hampshire Borders NHS Trust since its creation form the merger of the former Heathlands and North Downs NHS trusts in 1998.

Why a review was needed

1.5. In May 1994, National Health Service Guidelines were issued which require an "independent inquiry" to be held when a person in contact with mental health services commits a homicide. In these cases, AB, CD and EF all had contact with the mental health services but to differing degrees. AB and CD had also had contact with Social Services children and families services. In these circumstances the Hampshire and the Isle of Wight Strategic Health Authority and Blackwater Valley and Hart Primary Care Trust agreed that an independent review should be jointly commissioned. The approach to the review and its terms of reference were developed with the full involvement of Hampshire County Council Social Services Department and with the full support of the Director of Social Services.

Terms of reference

1.6. The terms of reference for the review are set out in a report dated 30 September 2003 to Hampshire and Isle of Wight Strategic Health Authority and Blackwater Valley and Hart Primary Care Trust. The Boards of both organisations agreed to the commissioning of the review along the lines set out in Sections 2 and 3 of that report. The report is appended as Appendix A. The key elements of the review were to include:

- An examination of the broad underlying causes of each of these three incidents
- To review in general terms progress on implementing the recommendations of the earlier Independent Inquiry into the care and treatment of ML, PH and CM
- Whether systems and processes are in place to minimise the possibility of such incidents happening again
- Whether services and practitioners have adapted their practices in the light of these incidents and the subsequent external and internal inquiry reports

1.7. The review would consider actions in relation to the original Independent Inquiry Report and the more recent internal inquiries into the care and treatment of AB, CD and EF and the subsequent action plans:

- Why the three further incidents occurred
- The robustness of the three internal inquiries and whether their recommendations were an adequate response to their findings
- Whether the action plans developed in response to the inquiries satisfy the recommendations
- The extent to which the action plans have been implemented
- Whether the changes have been absorbed into the culture of the organisations and the lessons understood and learned

1.8. The review would also consider broader organisational issues relevant to the incidents in relation to both mental health services and corporate and governance matters.

Who conducted the review?

1.9. The inquiry was undertaken by:

1.9.1. Malcolm Barnard (Review Team Leader) – Verita Associate – Former Area Director of Social Services and former senior NHS manager;

1.9.2. Dr Matthew Debenham – Consultant Psychiatrist, West Kent NHS and Social Care Trust;

1.9.3. Pauline Neill – Verita Associate - Former Director of Nursing Services;

1.9.4. Frank Rust (Lay Member) – Former Community Health Council Chairman.

How the review was conducted

1.10. The Strategic Health Authority (SHA), Primary Care Trust (PCT) and County Council concluded that while the three most recent cases should prompt a further independent review, this would not take the form of a traditional independent homicide inquiry. Instead the further work would be focussed on organisational learning and service improvement.

1.11. The intention was to pursue a less adversarial, more open and collaborative approach which would seek to address *why* the incidents occurred rather than simply *what* happened.

1.12. This required a new approach and a different style and methodology from traditional inquiries. For example we would not call witnesses, but we would seek meetings; we would not call for evidence, we would listen to views and perspectives; we would not focus the discussions on the detail of the individual cases (this had already been done in the internal inquiries), but we would look at the key organisational and service issues raised by the three cases. We would not therefore confine the review to talking only with people with a direct knowledge of the cases. But we would seek discussions with a wide range of groups and individuals working at different levels and in different organisations, to gain perspectives and views on the key issues and how well and effectively they had been addressed since the tragic incidents. We would seek to identify any further work needed to facilitate further learning and improvement and we would also seek examples of good practice and of significant progress to provide building blocks and encouragement for further development.

1.13. *The approach envisaged was, in our view, possible because the quality of the internal inquiries and subsequent action plans was good. Less rigorous initial internal investigations and/or less robust action plans and monitoring process may well have required a more traditional and formal external review.*

1.14. The approach developed by the Review Team was discussed, before the review commenced, with senior representatives of each of the commissioning organisations and with the Chief Executive and Director colleagues of the Surrey Hampshire Borders (SHB) NHS Trust. It was agreed that an "open door" question and answer session would be held before the field work meetings commenced in order to clarify the purpose of the review, its style and approach and to answer any questions.

1.15. The first step was therefore to review all relevant documents including the internal and external inquiry reports, subsequent action plans and policies and procedures. Appendix B provides a list of the documentation reviewed.

1.16. The Review Team then discussed the key themes identified from the documentation and action plans and produced a matrix showing ,for each theme, the policy, organisational, practice, criteria/thresholds, engagement or other issues we wished to explore. For example against the "Clinical Governance and Audit" theme we identified clarity, distribution and embeddedness as policy issues and incident reporting procedures as one of the practice issues.

1.17. The matrix also identified, for each theme, the key people we needed to meet to gain a range of views and perspectives to focus on and provide evidence for learning and service improvement opportunities. For the "Care Programme Approach" theme for example, we flagged up the need to discuss the identified issues with the Trust's Clinical Governance Committee, a ward inpatient management team and inpatient staff teams, a group of Consultant Psychiatrists, staff groups from specialist services e.g. drug and alcohol services and the Mother and Baby Unit and a Community Mental Health Team. Because of the engagement issues around the Care Programme Approach we also identified the need to discuss some questions with groups from partner organisations.

1.18. In this way we intended to discuss the key themes and issues with those responsible for developing, implementing and monitoring policy and also with those responsible for ensuring that the policy is carried out in front line patient care services. This would enable us to compare the views for example, of senior managers, clinicians, service managers and front line staff about the effectiveness and robustness of a particular policy or system and how well it was embedded into day to day practice.

1.19. For some key themes, for example "Risk Management and Assessment", we considered it necessary to make such comparisons of view between partner organisations. In such cases the key policy, practice, organisational development and training issues were discussed with a range of groups within the mental health services and also with representatives from other groups or partner organisations, for example the voluntary sector (via the North East Hampshire and Surrey Heath Local Implementation Team (LIT)); the Multi Agency Public Protection Arrangements (MAPPA); a Director of Housing; a group of Health Visitors; midwifery services and senior managers from Social Services from adult services and children and families services respectively. The intention again was to compare and contrast views and perspectives and to identify common ground in the quest to identify lessons, opportunities for closer partnership working and service improvements.

1.20. The Review Team drew up a list of all the groups of staff, teams, committees and individuals with whom discussion would be sought. These covered a wide cross section of the mental health services, social services, some services provided by the primary care trust, housing and the Multi Agency Public Protection Panel (MAPPA).

1.21. We also had the considerable benefit of a discussion with the mother of one of the victims. The families of the victims of the other two more recent homicides were invited to meet us or to submit their views and perspectives in writing. One family chose not to respond. The other replied that they did not wish to contribute. Whilst regretting that we did not have more opportunity to discuss the issues with relatives, we fully respect their decisions.

1.22. All other individuals and groups we wanted to talk to were willing and able to meet with us and we are most grateful for the honesty and openness with which participants approached our discussions. 32 such meetings took place during the fieldwork for the review. A list of the groups and post holders we met is included at Appendix C.

1.23. *The National Health Service Guidance (see Para. 1.5 above) covering the need for inquiries in cases of homicide involving people receiving care and treatment from the mental health services is currently under review. We believe that the approach we have taken to this Review could be one way in which the requirements of any future amended guidance could be met. Verita and the SHA will therefore, with the agreement of the commissioners of this Review, seek discussions with the Department of Health, the National Patient Safety Agency and the Health Commission about the evaluation and possible sharing and future use of this approach and methodology.*

2. Summary and Conclusions

This section is intended to provide an overview of our main conclusions. The evidence is included and discussed in the main body of the Report. Recommendations appear throughout the Report and are summarised in Section 7.

The overall picture to emerge from our review and field work was one of substantial improvement over the past two years in governance arrangements and in service delivery. The willingness we saw and heard from mangers and staff within the local mental health services and partner organisations to identify scope for improvement and to strive to achieve it, gives us confidence that the further development and improvements we have identified in planning, commissioning and delivering services in partnership, will be rigorously pursued in the coming months.

2.1. The lessons learned from the 2001 Independent Inquiry Report have been taken on board by the local mental health services. They have been used as building blocks for further learning from the three more recent internal homicide inquiries.

2.2. The three internal inquiry reports into the care and treatment of AB, CD and EF respectively, indicate a genuine attempt to learn lessons through rigorous investigation and a non defensive approach. The CD internal inquiry was particularly thorough and rigorous. In the other two internal inquiries, while the standard of investigation was generally good there were some issues which could have been explored in more detail or with more rigour. These are discussed in the body of this Report.

2.3. All three internal inquiries identified failings in systems and in the interfaces between services and systems. We were able to validate the effectiveness of the internal inquires and the subsequent action plans in this respect. It has not been necessary for us to pursue the issues of causation further since they were adequately addressed in the three internal inquires.

2.4. There were underlying cultural and organisational problems within the SHB Trust and its predecessor Trusts at the time of the homicides involving AB, CD and EF (i.e. around 2001/02 and before).Examples included: a lack of openness and poor processes in reporting incidents; a sense of "separateness" between component services within the Trust; a history of poor relationships with Trades Unions and a lack of cohesion between management and clinicians. This inevitably had a contributory effect to the climate in which systems and communications problems occurred.

2.5. Significant progress has been made by the SHB Trust, particularly in the past two years, in turning round that organisational climate and in tightening and improving systems and ways of working. These achievements are commendable given the extent of organisational change in the last few years.

2.6. Clinical Governance in the SHB Trust is now integrated, effective and is efficiently structured with good systems for monitoring and accountability. The Serious Untoward Incidents reporting and monitoring process is supported by staff, well managed and effective in learning lessons positively and putting improvements in place. Improvements in SUI reporting and monitoring are an example of how the Trust has implemented change as a result of the external and internal inquiry reports. The Action Plans developed as a result of the recommendations from the inquiries were comprehensive and well monitored. They adequately reflected the recommendations of the inquiries and have now been almost completely implemented. Further work is needed, however to improve dissemination of inquiry reports and action plans both within the SHB Trust and within relevant partner organisations.

2.7. The development of partnership working in the local mental health services, for example with users of services and their families and with the wider community, may have been slower than in some other parts of the country. The development of plurality in service provision within the local mental health services needs to be addressed, together with the relatively underdeveloped range of community resources for people with mental health problems.

2.8. There is opportunity for the relevant agencies to explore together and reach agreement on the future arrangements for commissioning mental health and social care services in the NE Hampshire and NW Surrey area. It will be essential to continue to recognise the needs of locality populations and the diversity of provision required to meet those local needs. The importance of developing and maintaining a consistent overview of the mental health and social care needs of the whole population of the catchment area should also be taken on board. Any improvements to commissioning arrangements could build on the foundations built by the work of the North East Hampshire and Surrey Heath Local Implementation Team (LIT).

2.9. Clear, well disseminated policies for the Care Programme Approach (CPA) are now in place with appropriately rigorous audit processes designed to identify improvements in compliance and practice. There is progress towards a high degree of "embeddeness" of the CPA process in the adult mental health services in the SHB Trust. More work is needed to facilitate participation in CPA from staff from partner agencies and from carers. The implementation of eCPA (the electronic system to support the CPA) has been relatively slow.

2.10. There is scope for an improved multi-agency view of and approach to risk management to reflect the partnership working needed for the planning, commissioning and delivery of comprehensive, modern services for people with mental health problems. This could support services working in partnership with the mental health services, for example the midwifery and health visiting services, in ensuring that their risk assessment processes and systems are adequate and robust. It could also support essential partnership working with child protection services and the multi-agency public protection arrangements (MAPPA). Such a partnership approach to risk management would also help to consider whether improvements could be made in the arrangements for sharing of information about risks between agencies, including the need for clarity about each agency's thresholds for access to services.

2.11. "Link Worker" initiatives developed by Acorn Drug and Alcohol Services and the Aldershot "Hollies" CMHT have been shown to work well in providing a conduit between services. There are opportunities to extend this model to facilitate joint working between other component parts of the mental health services and with partner organisations, for example housing departments and MAPPA.

2.12. Substantial progress has been made within the Mother and Baby Unit at Parkland's Hospital, Basingstoke, in putting improvements in place as a result of the recommendations of the internal inquiry into the care and treatment of CD.

2.13. Internal communications in the SHB Trust appear to be adequate. A wide range of mechanisms are in place to facilitate communication with staff. It will be important for the new, much larger Trust to ensure, as quickly as possible, that its internal communications are efficient and effective.

3. A brief overview of the cases

3.1. The following background information is extracted from the internal inquiry reports produced by Surrey Hampshire Borders NHS Trust.

3.2. AB

- AB was convicted of the murder of GH who died in Aldershot on 23 August 2001 as a result of stabbing

- During the years 2000 and 2001 AB received care and treatment from the mental health and substance misuse services provided by the Surrey Hampshire Borders NHS Trust. In this period she was also in contact with Hampshire County Council Social Services Department's Children and Families Services concerning her young daughter

3.3. CD

- On 2 November 2001 CD set fire to her family home resulting in her death and the death of her mother the following day

- CD who was 43 years old when she died, had first come into contact with the mental health services at the age of 25 when she was admitted in January 1983 to Frimley Park Hospital having made a serious and sustained attempt to end her life

- Further admissions were necessary in 1984, during which time CD's son was born, and 1995 following serious self inflicted injuries. CD was admitted to the Mother & Baby Unit (MBU) at Parklands Hospital Basingstoke in July 2001, following an overdose of anti - depressants. Her daughter was aged almost 10 months at the time. She was discharged from the MBU on 28 September 2001 and subsequently received support from a Community Psychiatric Nurse (CPN), a Health Visitor and a Care Support Worker

3.4. EF

- EF was convicted of the manslaughter of his girlfriend, IJ who died on 11 April 2002

- EF was reported to have attended a Child Guidance Clinic aged 14 years at a time when his behaviour at school deteriorated dramatically. He had also reported smoking cigarettes and sniffing lighter fuel from the age of eight years. From the age of 15 years onwards he took illicit drugs and by the age of 19 years he was using heroin

- In 1989 EF was assessed by a Consultant Psychiatrist whose report suggested that EF had a schizophrenic illness, masked by illicit drug use

- He was admitted to a psychiatric ward at Frimley Park Hospital in May 1990 and discharged in August 1990. In 1992 EF was admitted to Brookwood Hospital secure unit and a diagnosis of schizophrenia and drug induced psychosis was given

- EF's first contact with Acorn drug and alcohol services was in 1993. He self-referred to Acorn again in 1997 and 1998. He was seen again by Acorn staff between January and April 2002

4. The internal inquiries and action plans - a review of each case - lessons learned and the need for further action

The internal inquiries

Overview

4.1. In each of these three tragic cases the Surrey Hampshire Borders NHS Trust's serious untoward incidents policy was implemented. In all three cases internal inquiries were commissioned jointly by Surrey Hampshire Borders NHS Trust and Hampshire County Council.

Comment:

4.2. The joint commissioning of the internal inquiries was entirely appropriate in view of the joint responsibilities of both organisations for mental health services and the child protection issues which arose in two of the three cases.

4.3. All three internal inquiries were chaired by a Non – Executive Director of the Surrey Hampshire Borders NHS Trust and all three inquiry teams included an appropriate mix of senior and experienced practitioners and managers relevant to the key issues in each case.

4.4. The terms of reference for each internal inquiry were clear and comprehensive.

4.5. The reporting arrangements for each internal inquiry were clearly established and in each case a methodology for the inquiry was agreed and was described in the report.

4.6. Each internal inquiry team reviewed all available documentation and case records.

4.7. In each internal inquiry the relevant and appropriate staff and managers were interviewed, including those directly involved in the care and treatment of the individuals concerned.

4.8. The internal inquiry reports all include a history and/or chronology of the individual's care and treatment. They all provide an analysis of the key issues relating to the care and treatment, including key decision points and where policies, procedures and systems were not used appropriately or were inadequate for purpose. They all include a set of recommendations designed to facilitate improvements in services and to help minimise the possibility of such tragedies happening again.

Comment:

4.9. Comment: The three internal inquiry reports indicate a genuine attempt to learn lessons through rigorous investigation and a non-defensive approach. The CD internal inquiry was particularly thorough and rigorous. In the other two inquiries there were some issues which could have been explored in more detail or with more rigour. We have identified these in Paragraphs 4.12. and 4.23 to 4.25. below.

A brief commentary on each internal inquiry report

Joint internal inquiry into the care and treatment of AB

4.10. This internal inquiry report is appropriately cross referenced to an "overarching" report which brought together common issues and lessons to be learned from a cluster of three methadone related deaths. One case resulted in the death of a 17 year old woman who died in June 2000 after taking methadone supplied by a 33 year old man (KL) who was attending the Surrey Hampshire Borders NHS Trust's Acorn Prescribing Clinic. The second case concerned an 18 year old man (MN) who died in April 2001 of bronchopneumonia and methadone toxicity. MN had not been a patient of Acorn Services. The third case was that of AB. The overarching report identified differences in the circumstances of each case and, in overview, identified common factors. In summary the report concluded that there were, in each of these three methadone related cases, extensive opportunities to improve mental health and substance misuse services to vulnerable adults and children. These related to:

- Communication between services
- Quality of written records
- Care planning and care programme approach (CPA) processes
- Risk assessments
- Clinical skills and practice in substance misuse services

4.11. The membership of the internal inquiry team included a Consultant Psychiatrist and Senior Lecturer in Addictive Behaviour from outside of the Trust. This provided added levels of both expertise and independence.

4.12. Whilst recognising the generally comprehensive and robust nature of the internal inquiry, the Review Team has the following observations on the content of the report:

- The section on the history of AB's care and treatment could have benefited from a fuller description of the immediate circumstances of the fatal stabbing of GH by AB
- A summary of any relevant earlier medical or social history of AB would have been helpful
- The linkage between deliberate self harm services, accident and emergency services and mental health services could have been explored further
- The sections on "findings", linked to the descriptions of each services' involvement with AB's care and treatment, are otherwise comprehensive and deal with the issues identified in the earlier "history" and "chronology" sections of the report
- The recommendations in the report are clearly identified for each of the respective services. They are clear and comprehensive.
- However the addition of a recommendation related to criteria and thresholds for acceptance onto caseloads and to eligibility for CPA would, in our view, have been helpful. This could have been included in the recommendations related to the findings regarding the Hollies CMHT
- The recommendation at Para. 3.21 (Rec.4) of the internal inquiry report could have helpfully included a reference to the potential need for training needs analysis for children and families social work teams in relation to substance abuse to be extended across Hampshire and beyond the confines of the Aldershot Team

Joint internal investigation into the care and treatment of CD

4.13. The report of the investigation reflects the terms of reference set by the joint commissioners.

4.14. Membership of the investigation panel included an appropriate mix of experienced and senior managers and clinicians, including a Consultant Psychiatrist from outside the Surrey Hampshire Borders NHS Trust.

4.15. The report indicates that the investigation was thorough and rigorous. The panel heard oral evidence from 17 individuals who had been involved in the care and treatment of CD.

4.16. The report provides a detailed summary of CD's contact with the mental health services dating back to 1983. This was relevant and helpful information in view of the two episodes of severe mental illness associated with her two pregnancies and the births of her two children in 1984 and 2000 respectively.

4.17. The report dealt with the "critical period" between March 2000 and the tragic events of November 2001. It provided a detailed description of the care and treatment CD received and the interface, interaction and communication between services; both within the mental health services and between mental health services, Midwifery, Health Visiting and Social Services for children and families.

4.18. It also provided a chronological summary of the key events and issues and highlighted the comments of the panel and their recommendations. The commentary was particularly helpful in demonstrating the thinking behind many of the panel's recommendations. The chapter ends by covering some general issues relating to supervision and training, again with a commentary and recommendations.

4.19. In view of the importance of the child protection issues in this case relating to CD's young daughter, DD, a chapter of the report is devoted to highlighting the panel's findings in relation to the care of DD. This chapter again includes a summary of the key events, commentary and recommendations.

4.20. The report ends with a summary of recommendations cross referenced to the terms of reference for the investigation.

Comment:

4.21. This was a tragic, complex and therefore difficult case to investigate. We have looked at all the documentation and at the report of the investigation. We believe it was a particularly well constructed, executed and reported internal investigation which covered all the key events and produced recommendations to address the key issues and weaknesses identified.

Joint internal review of the care and treatment of EF

4.22. The internal inquiry report reflects the terms of reference provided by the joint commissioners.

4.23. The "methodology" chapter indicates that following initial review of the medical notes relating to EF, the panel decided that the relevant period for investigation was from January 2002 to the date of the incident in April 2002.

Comment

4.24. ***We felt that this could have had the effect of taking too narrow a view of the history and events around the care and treatment of EF. However the report went on to deal with social and medical history, to provide a reasonable summary of EF's social history and of his involvement with mental health and substance abuse services from 1989. The restriction in the time span for the investigation did nonetheless mean that some questions arising from the history were not addressed. For example, EF's status in terms of CPA in the period 1993 to 1996 is unclear from the report. Yet eligibility for and delivery of CPA for people with severe and enduring mental illness and drug dependency is often a key issue in such cases, particularly where care planning needs to be shared across or between adult mental health and drug misuse services. These issues could have been explored in more detail by the internal inquiry.***

4.25. Comments and recommendations in the internal inquiry report were included in a "critical period commentary". This is a generally well presented and argued section of the report and recommendations are logical, relevant and appropriate. However we consider that some questions arising from the evidence remained unasked or unanswered in the report. For example:

- The reason for the referral of EF to the Acorn Community Drug Service on 7 January 2002 by the Outreach service is neither explored nor explained
- Whilst the commentary regarding the structure of Acorn provides useful organisational context it does not indicate or comment upon whether this impacted on the care of EF
- The report states that communication links between Acorn and mental health services were reported to have been unsatisfactory for many years. It does not, however, go on to consider the effect this may have had on EF's care and treatment, for example in relation to care planning and CPA
- The issues arising from EF's appointment with the Locum Consultant Psychiatrist and his Acorn key worker on 6 February 2002 could have been explored with more rigour. We accept however that the report's recommendations, concerning retrieval of previous records, record keeping, mental health assessments and training in risk assessment and risk management, did cover the key concerns arising from that episode
- Questions could have been asked about the existence of a care plan, for example at the point of EF's appointment with the Locum Consultant Psychiatrist on 6 March 2002
- It would have been useful to have included more detail of the reason for the Children's Bureau's telephone call to the Acorn key worker on 22 March 2002. What, for example was the role of the Children's Bureau at that time and how were they aware of EF's deteriorating behaviour?

The action plans

Overview

4.26. The Review Team have examined action plans developed by Surrey Hampshire Borders NHS Trust, with input from partner agencies, in respect of each of the three cases, (ML,PH and CM) covered by the External Inquiry Report published in July 2001. We have also examined the action plans similarly developed in response to the internal inquiry reports into the care and treatment of AB, CD and EF.

4.27. The implementation of all action plans has been subject to a formal scrutiny process within the Surrey Hampshire Borders NHS Trust with participation from partner agencies. The scrutiny process is in turn linked through reporting processes to the Trust's clinical governance arrangements and to the Trust Board.

4.28. In all six cases, the format of the action plans was standardised to include the relevant recommendation, action recommended, and action to date, by whom action was being/to be taken and ongoing reporting requirements. For the latter cases concerning AB, CD and EF the format was improved in October 2003 with the addition of a requirement to include evidence of action or implementation in the action plan update reports to the Serious Untoward Incident (SUI) Scrutiny Panel.

4.29. Scrutiny Panel meetings were all formally minuted and the minutes were received by the Trust's Clinical Governance Committee. We have seen the minutes of Scrutiny Panel meetings in respect of the six cases, held on 30 April 2003, 23 July 2003, 8 October 2003, 16 January 2004, and 2 April 2004. We were aware that further regular meetings were scheduled in 2004 to continue the monitoring and scrutiny process. The Scrutiny Panels were normally chaired by one of the Trust's Joint Directors for Clinical Governance. Other panel members included the Director of Nursing and the County Manager, Mental Health Operations, Hampshire County Council Social Services. The Panel meetings were well attended by clinicians, practitioners and managers involved in the implementation of agreed actions from within the Trust and where appropriate from partner organisations, for example Social Services and the Primary Care Trust.

4.30. By July 2003 it had become clear that a number of common themes had emerged from the AB, CD and EF cases being monitored by the Scrutiny Panel. It was therefore decided to set up, in addition to the action plans for the individual cases, a series of "themed action plans". The following themes were identified:

- CPA
- Acorn (drug and alcohol services)
- Adult mental health services
- Communication/linkage
- Record keeping
- Child protection

4.31. Each themed action plan identified the source recommendation, the action taken/to be taken and the evidence to identify progress and implementation.

Comment:

4.32. ***We found the action plans overall to be of high quality, fully reflecting the recommendations of the external and internal inquiry reports. The action plans were regularly updated for each Scrutiny Panel meeting. The process was driven by a desire to enable the relevant organisations to learn from these tragic and distressing incidents and to ensure that where the need for changes and improvements had been identified, these were embedded in practice. The seniority of Scrutiny Panel membership and the chairing of the Panel by Executive Directors of the Trust ensured that good, direct links were made at the Clinical Governance Committee and at Board level. The development of themed action plans enabled the organisations to look at the lessons to be learned from the perspective of a number of cases across a wider range of services and staff. We commend this approach to action planning and to the monitoring and scrutiny of progress towards implementing change and improvement.***

A brief commentary on each action plan

ML, PH and CM

4.33. Twenty one findings and actions were identified by the external inquiry report, published on 24 July 2001. These formed the basis of an action plan, developed over the following year by a small multi-agency group. Some of the actions were appropriately broken down into manageable pieces of work and subsequently identified in revisions to the action plan. The action plan was considered by the Surrey Hampshire Borders NHS Trust (SHB Trust) Board in June 2002. The report included work signed off or passed to other groups and identified work underway or still outstanding.

Comment:

4.34. From the time lapse of a year between the commissioning of work to develop the action plan and reporting back to the Trust Board, it seems that initial progress was slow. By August 2002 however, it was clear that work on implementing recommendations and agreed actions was underway. Implementation was monitored by the Scrutiny Panel once it was up and running in April 2003.

4.35. By April 2004 all but four of the original 21 actions had been signed off as completed. Two of the identified "sub-sets" of work were also not yet completed. In respect of the incomplete work, the further action required was identified together with the individual or organisation responsible for taking it forward. Issues relating to those parts of the service to be managed from 1 April 2004 by the Hampshire Partnership NHS Trust, (following a reconfiguration of responsibilities for mental health services), were identified and responsibility was agreed for ensuring that those outstanding issues were communicated. On this basis it was proposed that the Scrutiny Panel should conclude its work on these cases.

4.36. We return to the question of whether changes have become embedded in practice later in this report.

AB, CD and EF

4.37. Action plans were developed in response to the recommendations of each of the internal inquiry reports individually. The AB inquiry report contained 36 recommendations, the CD report 25 and the EF report 21 recommendations. These formed the basis of the respective action plans. In addition the themed action plans described in Para. 4.30. above related to these three cases.

Comment:

4.38. Having carefully reviewed the internal inquiry reports and all the action plans we are satisfied that the action plans adequately reflect the inquiry recommendations.

4.39. By January 2004 there was evidence to support the following levels of implementation for each set of recommendations:

- **AB:** Of 36 actions identified 14 were completed and 3 partially completed
- **CD:** Of 25 actions identified 11 were completed and 5 partially completed
- **EF:** Of 21 actions identified 11 were completed and 6 partially completed

4.40. Further progress was evident by April 2004 as follows:

- **AB:** 26 actions completed and 2 partially completed
- **CD:** 15 actions completed and 4 partially completed
- **EF:** 15 actions completed and 3 partially completed

4.41. The evidence to support this level of implementation is drawn from the documentation in action plans, minutes of Scrutiny Panel meetings and reports to the Scrutiny Panel. It is supported by our discussions with a number of members of the Scrutiny Panel, people attending Scrutiny Panels with responsibility for implementation of aspects of the action plans and our fieldwork meetings with groups of staff and managers.

4.42. Of the partially completed and/or not yet completed actions (at April 2004), all but three were identified actions for the SHB Trust; one was for joint action by the SHB Trust and Social Services and two were for joint action by the SHB Trust and PCT's.

4.43. The range of issues covered in those actions not yet fully implemented can be broadly grouped as follows:

- Linkages between services and agencies, including referrals, joint protocols and attendance at meetings
- Recording of information in client records
- Sharing of information, including access to records
- Risk assessment procedures
- Guidance regarding non- compliance with medication
- Training of non mental health professionals in mental health issues
- Staffing
- Range of therapeutic interventions available in Acorn Drug and Alcohol Services

4.44. Whilst the number of actions completed offers some insight into the progress made in terms of completion of identified tasks, it does not measure the extent to which changes have been absorbed into the culture of the organisation and embedded in practice. Our meetings with a cross section of practitioners and managers within the Trust and its partner organisations were intended to test those questions further. Our findings on those issues are discussed in Sections 5 and 6 of this report.

Lessons learned and the need for further action

4.45. From a close examination of the action plans and our discussions with managers responsible for their implementation and monitoring, we can conclude that the key lessons have all been *identified* and that responsibility for ensuring that they are turned into improvements in practice has been appropriately allocated. Our meetings with a wide range of staff, managers and clinicians at all levels of the organisations, suggest that some of the lessons have been fully taken on board and are reflected in improved practice. For example a rigorous process of audit of record keeping has been implemented across the Surrey Hampshire Borders Trust and such audits have been carried out more frequently in Acorn Drug Services where particular problems were identified. The "front-line" staff groups we spoke to all confirmed this and expressed their positive attitudes and approach to the audits. These comments were affirmed by those responsible for carrying out the audits and by other staff not in direct line management of the services, for example the Nurse Consultant.

4.46. A number of similar examples support the view that actions have been or are in the process of being implemented at the service delivery level: For example actions in relation to CPA processes, compliance and audit; review by Hampshire Social Services of the practice of and guidance given to Community Support Workers; provision of training of Acorn staff in risk assessment and risk management; and invitation of Acorn workers to child protection case conferences have demonstrably been implemented.

Comment:

4.47. ***Progress towards implementing the agreed actions has, after a fairly slow start, been generally satisfactory. It has been driven by a tight and disciplined scrutiny and monitoring process. However the actions identified but not yet completed (see Paras.4.42 and 4.43. above) include some significant opportunities for further improvement. Their implementation should be completed as soon as possible.***

Recommendation:

4.48. **The SHB Trust's Scrutiny Panel should, at the earliest opportunity, highlight each agreed action not yet addressed or partially completed. The Panel should formally agree a timetable, responsible organisation and responsible officer for each "non-completed" action to be implemented with a target date for completion. Any difficulties in meeting agreed timetables should be discussed by the Scrutiny Panel Chairman with the Chief Executive of the responsible organisation.**

5. The organisational issues

Background and context

5.1. Even in a national context of frequent changes to the organisational framework for the delivery of mental health and primary and community health care services over the past decade, the number of changes to the structure for such services in North East Hampshire and the North West of Surrey has been unusually high. This may be partly because of the continuous large urban area which includes, Farnborough and Aldershot in Hampshire and Camberley in Surrey. This could be seen as one "natural" urban community, bisected by a county boundary.

5.2. Surrey Hampshire Borders (SHB) NHS Trust was formed in April 1998 from the merger of North Downs Community NHS Trust and Heathlands Mental Health NHS Trust. On 1 April 2001 the SHB Trust took on responsibility for the wider catchment area of North Hampshire following the dissolution of North Hampshire Loddon Community NHS Trust on 31 March 2001.

5.3. With the establishment of primary care trusts (PCTs) during 2002 across the former North and Mid Hampshire and West Surrey Health Authority areas, the SHB Trust relinquished responsibility for community health services and became a specialist mental health and learning disabilities NHS trust. This change had to be managed over a relatively long period of time because PCTs developed at differing paces in Hampshire and Surrey respectively.

5.4. The SHB Trust relates now to two Strategic Health Authorities (SHAs), the Hampshire and Isle of Wight Strategic Health Authority and the Surrey and Sussex Strategic Health Authority.

5.5. On 1 April 2004, the communities served by the SHB Trust changed again with the transfer of mental health, learning disabilities and substance misuse services and staff in the North Hampshire locality (centred on Basingstoke), to the new Hampshire Partnership NHS Trust. The SHB Trust currently serves a population of around 525,000 people in the communities of the PCTs covering Guildford and Waverley, Blackwater Valley and Hart and Surrey Heath and Woking.

5.6. From 1 April 2005 the SHB Trust will cease to exist as it merges with Surrey Oaklands and North West Surrey Mental Health Partnership NHS Trusts to form the new Surrey and Borders Partnership NHS Trust providing NHS mental health, learning disabilities and substance misuse services for the whole of Surrey and the north-west corner of Hampshire including Aldershot and Farnborough.

5.7. The new mental health Trust will be one of the largest in the country. Like the SHB Trust it will work across the county boundary between Surrey and Hampshire. We understand that the relationship between the new Trust and Hampshire County Council Social Services will be facilitated by an agreement under which Surrey County Council Social Services will represent the interests of their Social Services colleagues in Hampshire on partnership and strategic issues. The new Trust will continue to relate to two Strategic Health Authorities.

5.8. The SHB Trust have indicated that because of the differential pace of development of PCTs within two SHAs and the need to work with two County Councils, there has been an absence, from the Trust's viewpoint, in the Surrey Hampshire borders area, of lead or joint commissioning arrangements for mental health services across the SHB catchment area as a whole. The Trust added that a strategic perspective does now appear to be emerging in Surrey and Sussex. A framework for joint commissioning had been in place for the greater portion of Hampshire for some time. It had though been difficult, according to the Trust, to move the strategy forward in the Surrey/ Hampshire borders area, because of the border issues, the uncertainties around service configurations and the forthcoming merger of mental health Trusts.

5.9. The view of the senior managers we spoke to in Hampshire County Council Social Services Department, responsible for adult services, was that joint commissioning arrangements for mental health services needed to be strengthened. They added that this would need to be addressed with the new PCT cluster arrangements.

5.10. The Blackwater Valley and Hart PCT consider that the joint commissioning issues covering the NE Hampshire locality and its cross border issues has, partly because of the complexity of the cross boundary issues, been innovative, extensive and relatively well developed. The PCT point, as an example, to work with the Hampshire and Surrey Social Services Departments and the SHB Trust to develop and implement a cross boundary provider locality for the area. A further example of effective joint commissioning is the joint work between the PCT, the Hampshire and Surrey Drug Action Teams, neighbouring Surrey PCT's and the SHB Trust to produce a single commissioning strategy for substance misuse health services.

5.11. The need for further debate and joint decisions about future arrangements for planning and commissioning mental health services for the Surrey/ Hampshire borders area is discussed in Paras. 6.2. to 6.15. below.

5.12. The SHB Trust has needed to focus significantly on financial recovery over the past two years. This has been successful in bringing income and expenditure on services into balance.

5.13. The SHB Trust has been awarded two stars in the latest star rating announcements; an improvement on its previous one star rating. Targets achieved were:

- Community mental health team (CMHT) integration
- Mental health minimum data set implementation
- Improving working lives
- Assertive outreach implantation
- Financial management

5.14. Targets not achieved were:

- eCPA (electronic care programme approach) implementation
- Hospital cleanliness

Comment:

5.15. The Surrey Hampshire Borders NHS Trust has, since it was established in 1998, managed constant changes in its catchment area and its portfolio of services. It has also needed to develop working relationships with two Social Services Departments in Surrey and Hampshire respectively and more recently with two Strategic Health Authorities and PCTs developing at differential timescales. The task of managing such change in order to minimise disruption to front line services and to ensure that staff are well managed and supported as they join or leave the Trust as a result of organisational reconfigurations, should not be underestimated.

Mental health issues

5.16. In considering the "broader organisational issues" relevant to the incidents of homicide as required by our terms of reference, we identified from the internal inquiry reports, action plans and associated documentation, the following key areas for review:

- Care programme approach (CPA)
- Risk management and risk assessment
- Incident reporting
- Communications
- Specialist services

5.17. All relate, for the purposes of this review, to adult mental health services rather than to the full range of services provided by the SHB Trust and its partner organisations. We were also concerned to examine the relationship between the component parts of adult mental health services and their relationship in turn with specialist services and other key services like child protection, housing, public protection (Multi Agency Public Protection Arrangements (MAPPA)), health visiting and midwifery.

5.18. The review included an examination of relevant policies and procedures (please see Appendix B) and meetings with a wide range of management and staff groups from within the adult mental health services and partner organisations. Our findings are therefore informed by a mosaic of views and perspectives from different levels and across different organisations working within or alongside the mental health services in the Surrey Hampshire Borders area. These included an overview of human resources, training, development and education issues provided by the SHB Trust's former Director of Human Resources, current Interim Director of Human Resources and former and current Education and Training Managers. Rather than include a separate section to deal with education, training and development issues we have included them wherever appropriate throughout this report.

5.19. The Review focussed mainly on adult mental health services in the area of North East Hampshire centred on Aldershot and Farnborough. This is because all three incidents involved patients who lived in that area. The policy and procedural context was however for the whole area covered by the SHB Trust.

Care Programme Approach (CPA)

5.20. We reviewed all SHB NHS Trust's policies and procedures relating to the Care Programme Approach. The current overarching operational policy was issued in January 2003 having been approved in November 2002. It was distributed to all SHB Trust policy manual holders, i.e. to all relevant operational managers. The policy provides a clear and comprehensive guide to the scope, components and operation of CPA across the Trust. It provides for a localised programme of clinical audit to monitor the implementation and operation of CPA and for the results and action plans arising from the audits to be developed and monitored through local management structures and clinical governance forums.

5.21. A number of concerns about the operation of CPA within the Trust and between component parts of the service had been raised in the internal inquiries into the care and treatment of AB, CD and EF. It is not proposed in this report to track every recommendation and its implementation progress. That work has been undertaken by the Trust in its action planning and scrutiny processes. However we were keen to discuss the implementation of some of the key recommendations concerning CPA with groups of staff and managers to test the degree to which key changes had become embedded in practice.

5.22. The Trust's Executive Team told us that most of the recommendations concerning CPA had been implemented. However eCPA, the electronic system to support the operation of the care programme approach was currently being rolled out and was not yet available and in use across the Trust as a whole. This position is broadly supported by the evidence of implementation presented to the Trust's SUI Scrutiny Panel.

5.23. We met the General Manager and staff group of the Acorn Drug Service separately. Both meetings conveyed a perception of significant progress within Acorn over the past two years in accepting CPA as the central means of ensuring that specialist assessments of people with dual diagnosis (i.e. substance misuse and a diagnosed mental illness) result in a co-ordinated care planning process. This view was largely confirmed in our meetings with other staff working elsewhere in the adult mental health services but working in partnership with Acorn, for example CMHT staff and staff of Wingfield ward inpatient services. Acorn staff also confirmed that in all cases the CPA co-ordinator is from the relevant local CMHT. Acorn staff and management all showed an awareness of the Trust's CPA policy and knew where to access a copy.

5.24. The message we received from other managers in the adult mental health services regarding the extent to which CPA was embedded in practice was broadly similar. One manager felt that "it works but it could work better" and went on to tell us that to some extent CPA is still seen by some parts of the service as "the forms". Managers confirmed that the clinical audit process is used to monitor CPA compliance and that this had identified a few occasions where patients had been discharged without a CPA meeting and without the care co-ordinator being aware. This was seen as a positive indication that non-compliance was being picked up by the audit system and addressed. The outcomes of audits and regular meetings to review the CPA process are reported to Locality Managers and the Trust's CPA Development Officer and fed into the Clinical Governance Committee through its regular reporting cycle.

5.25. An additional perspective from another specialist service was provided by staff at the specialist Mother and Baby Unit at Parklands Hospital Basingstoke, a tertiary regional admissions unit covering a large geographical area, "from Tunbridge Wells to Portsmouth". The staff told us that the CPA process was "very good and in place". For patients from the SHB Trust, care co-ordinators were nominated from the relevant CMHT.

5.26. The SHB Trust's CPA Development Officer has been in post since May 2000 and has an Approved Social Worker and Social Services background. She wrote the Trust's CPA operational policy to implement national guidance. She is responsible for co-ordinating CPA issues across the Trust and therefore has an overview of what is happening across the organisation. She also has responsibility for CPA education and training and feeds into the development of Trust's training and education programme. The main challenge has been to ensure that all staff conform to the CPA process so that there is uniformity of practice with regard to CPA. Her main focus at present is the introduction of eCPA.

5.27. The involvement of carers in CPA is , in the view of the CPA Development Officer, more advanced in Hampshire than in Surrey because Hampshire have employed Carers Support Workers who undertake carers' needs assessments which can help achieve and sustain engagement with the CPA process. The SHB Trust provides training and support input for service users and carers around CPA through "awareness sessions". Blackwater Valley and Hart PCT were able to tell us about progress in the deployment of Carers Support Workers in its catchment area and in neighbouring areas of Surrey. As part of the work of the North East Hampshire and Surrey Heath Local Implementation Team (LIT), commissioners have addressed issues about the lack of Carers Support Workers and targets for their deployment in both North East Hampshire and Surrey have been achieved.

5.28. An encouraging development has been to see CPA issues increasingly raised within teams through their local clinical governance groups as well as through the more formal reporting mechanisms to the Clinical Governance Committee.

5.29. We also heard evidence of local monitoring of the CPA process within the normal line management arrangements. For example the management group for Wingfield Ward told us about their monthly CPA development meetings. Their view was that three or four years ago the Trust had "different CPAs" but there was now one system. They described a good relationship with care co-ordinators from the CMHTs who visit their patients on the ward regularly during periods of inpatient care. The ward management group's view was that "CPA is now the major foundation of patient care".

5.30. The centrality of CPA to patient care in the inpatient unit was confirmed for us when we met staff from Wingfield Ward. They told us that "no patient is now discharged without a CPA" and reiterated that the CMHT appoint a care co-ordinator for every patient subject to CPA; an arrangement they clearly felt was working well and which had helped joint working with the CMHTs. One of the internal inquiry reports had suggested that inpatient services staff had, at that time, regarded CPA as mainly a matter for community staff and as applying mainly to discharge from inpatient care. We put this to the Wingfield ward staff group. Their response was that CPA is a "continuous process now". It is "used all the time". The staff group's view was that CPA works well now for inpatients. The process has helped to improve liaison between the Ward and CMHTs and has facilitated improvements in patient care, for example in planning for relapse prevention.

5.31. To gain a primary health care perspective on CPA we met the lead GP for mental health services for the Blackwater Valley and Hart PCT. She told us that GPs do now get invited to CPA meetings, although they rarely attend because of constraints on their time. She felt that more notice of the date and time of CPA meetings might be helpful.

Comment:

5.32. ***This was a comment reiterated independently by other potential invitees, e.g. housing services, Acorn Drug Services and social services for children and families.***

Recommendation:

5.33. The SHB NHS Trust should review the arrangements for scheduling CPA meetings to allow for a longer period of notice of the meeting time and date for those invited to attend.

5.34. The lead GP added that GPs receive a copy of the CPA form and where appropriate a letter from the Consultant Psychiatrist. She felt that brief updates on the patient's progress might also be helpful to GPs. Information on discharges from hospital was, in her experience, timely and appropriate, including a faxed letter initially followed up by a full discharge letter.

5.35. Our meeting with 10 staff members from various disciplines in the "Hollies" Community Mental Health Team (CMHT) confirmed many of the views and perspectives reported in previous paragraphs. The team told us that all CPA co-ordination is now undertaken through the CMHT. They were also able to offer examples of improved relationships with the Acorn drug services and with inpatient services. This has been assisted by the nomination of link workers from the CMHT. For example a Community Support Worker from the CMHT now visits Wingfield ward every week and then provides support for patients when they return to the community. A liaison meeting with inpatient and day hospital services has been established on a regular, fortnightly basis. Issues of concern to the CMHT do, however, still occasionally arise. For example there have been occasions where weekend leave from hospital has been agreed without the knowledge of the care co-ordinator. These issues are nevertheless being picked up jointly by the CMHT manager and the Modern Matron to ensure that improvements can be identified and implemented.

5.36. With regard to links with the midwifery services , the Head of Midwifery Services at Frimley Park Hospital told us that midwives were involved in CPA, although not often. This was probably because there were not many cases where such involvement was needed. The midwifery service do receive copies of CPA care plans occasionally and very occasionally midwives visit the inpatient services at the Ridgewood Centre or inpatient mental health services staff visit the midwifery unit at Frimley Park Hospital.

5.37. We met with a group of seven Health Visitors serving the Aldershot area. They confirmed that they receive occasional invitations to attend CPA meetings for their clients who are patients at the Mother and Baby Unit. Their experience of those meetings at the MBU was described as good. They also, very occasionally received invitations from the CMHT to attend CPA meetings. The group did not feel they had enough experience of CMHT co-ordinated CPA meetings to comment on them.

5.38. The group of Consultant Psychiatrists we met included the Trust's Medical Director, the Clinical Director for adult mental health services, the Locum Consultant Psychiatrist working with the Acorn drug services and the Consultant Psychiatrist for the specialist Mother and Baby Unit at Parklands Hospital Basingstoke. Their view was that CPA had certainly improved over the past two years. They saw CPA as "very paper heavy" but accepted that the process does provide "triggers for action".

5.39. The views of the Head of Risk Management for the SHB Trust and the Complaints Advisor were that CPA and risk assessment were well embedded in the Trust's clinical governance process. They felt that relationships between CMHT's and inpatient services were much improved. Complaints from service users or carers about the CPA process were reported as "rare".

5.40. From the perspective of Hampshire Social Services adult services, CPA in the SHB Trust was viewed to be "as good as elsewhere in the county". It was seen as still suffering from being viewed as a bureaucratic paper work system. However it was regarded as being well embedded but with some variance in the quality of process and outcomes. Effort to develop the CPA process, for example through service users' "recovery conferences" were commended by Social Services as examples of good practice in the Trust.

5.41. The Local Implementation Team (LIT) was established initially to monitor and support the implementation of the National Service Framework (NSF) for mental health. It is now essentially a planning framework group which pulls together a wide range of interested and expert individuals from all sectors with an interest in mental health across North East Hampshire and North West Surrey. Their views on CPA focussed not so much on how it is working but more on thresholds for access to CPA for service users. Concern was expressed that the threshold was too high i.e. the criteria for service users to have a severe and enduring mental illness in order to be subject to CPA excludes a large number of people with mental health problems from the process. Some members of the LIT also expressed concern that when CPA is applied, the process of continuing care is often not continued for long enough.

Comment:

5.42. ***Whilst we have some sympathy for these views from the LIT, the question of thresholds is essentially a national and not a local one. We would however regard it as important that a strong and consistent commissioning view is taken about thresholds for CPA and the closely associated issue of the development of primary mental health care services***.

5.43. ***The overall picture we received was of clear, well disseminated operational policies for CPA with appropriately rigorous audit processes designed to identify improvements needed in compliance and practice. Our meetings served to confirm a perception of progress towards a high degree of "embeddeness" of the CPA process in the adult mental health service in the SHB Trust and within the associated specialist services. More work is needed to facilitate the participation of staff from partner agencies (See recommendation at Para. 5.33. above) and carers. The implementation of eCPA across the Trust has been relatively slow, but the current roll out programme should ensure that it is fully in place within the next 12 months.***

5.44. Paragraphs 5.46 to 5.70 below deal with risk assessment and risk management. Paragraphs 5.62. 5.63. and 5.67. include commentary on the essential links between CPA and the patient risk assessment and patient risk management processes.

Recommendation:

5.45. **The SHB Trust should examine ways of forging closer links between CPA and the patient risk management process. Particular attention should be given to the need to build in the use of appropriate risk assessment tools to the CPA process. This should aim to ensure that risk assessment is confirmed as an integral part of CPA and may help to overcome any remaining views of CPA as a "bureaucratic paper exercise".**

Risk management and risk assessment

5.46. We reviewed the Trust's risk management strategy, issued in February 2003, having been approved in January 2003. It outlines the aims and objectives for risk management within the trust for both clinical and non-clinical risk. It includes a core risk management standard document. An independently assured risk management system is in place, to comply with national standards and which meets NHS and other requirements for the management of risks, hazards, incidents, complaints and claims. We also had the benefit of reading the Risk Pooling Schemes for Trusts (RPST) report dated 29 January 2004 on the Trust's compliance in relation to the RPST risk management standard and the Clinical Negligence Scheme for Trusts (CNST) assessment (at level 1) report dated January 2004 on risk management standards.

5.47. The outcomes of these independent assessments were: CNST Level 1 – "compliance". This entitles the trust to a discount from its CNST contribution for the following year and gains eligibility to apply for a level two assessment after 1 April 2004. RPST level 1 –"compliance".

5.48. The CNST report indicates that the Trust should be very pleased at achieving a level 1 assessment. High levels of compliance were assessed in respect of most standards. We noted however that within standard 8 – "the management of care in Trusts providing mental health services" - and relating to the standard "all staff undertaking assessments of service users have received appropriate training", a partial score was awarded because there was no evidence of medical staff receiving training in assessment (nursing staff do receive training as part of CPA training) and because there was no job description seen for the Executive Director with responsibility for CPA in the Trust.

Recommendations:

5.49. The SHB Trust should ensure that the training of medical staff in assessment through their participation in CPA training is implemented as soon as possible.

5.50. The SHB Trust should ensure that the responsibilities of the Executive Director responsible for CPA (the Interim Director of Operations) are outlined in the job description for that post as soon as possible.

5.51. The Trust's Head of Risk Management has responsibility for the implementation of the risk management strategy. She told us that processes for risk management and risk assessment had improved, particularly over the past two years. The message that "risk management is everyone's business" is communicated both through the induction programme to all staff and via awareness training. Dissemination of good practice is managed from the Risk Management Committee, which now reports direct to the Trust Board, into the Clinical Governance Committee and through team briefing to all staff. The risk register, which was made available for us to examine, provides a helpful overview of key risks within the Trust and informs the Directors in identifying "top" risks for consideration by the Board.

5.52. The SHB Trust's Risk Management Committee was set up in its current form early in 2004. It succeeded a previous risk management group which was a sub-group of the Clinical Governance Committee. The Committee is now chaired by a Non Executive Director of the Trust and reports formally to the Trust Board every month. The Committee told us of their concern to ensure that learning is disseminated. Team briefing was, they confirmed, used as one of the mechanisms for this. The Committee were able to provide two recent examples of risks identified and actions taken to demonstrate a two way line of communication and action. These concerned incidents identified through the incident reporting process and the complaints procedure regarding destruction of records and use of restraint.

5.53. The Risk Management Committee also shared with us their view that the reporting processes worked well. Staff were "generally eager to identify risks" and the serious untoward incidents reporting culture was said to be good.

Comment:

5.54. ***This view was subsequently largely confirmed in our meetings with front line staff and managers.***

5.55. We were however told by the Risk Management Committee that the problem with reporting of "near miss" type incidents to ensure that they are used positively (as "good catches") to minimise the possibility of similar incidents happening again, was not so much to do with reluctance to report, but more that people are not sure about the thresholds for reporting.

Recommendation:

5.56. **The SHB Trust, through the Risk Management Committee, should consider ways of clarifying the threshold for reporting "near misses", perhaps through a workshop involving staff and managers from different levels and a cross section of the Trust's services.**

5.57. The Interim Director of Human Resources confirmed that risk management issues were fed into the Trust's education, training and development programme. Recent examples were: infection control and MRSA.

5.58. Little progress was reported yet in looking at risk issues or risk assessment with partner organisations. The Risk Management Committee accepted that there were opportunities to do so with Social Services, Housing and MAPPA and through the LITs.

5.59. In a number of our fieldwork meetings issues were raised around sharing information about risk to patients of harm to themselves or others. Those raising concerns included Mrs J, the mother of one of the victims, the Consultant Psychiatrists, Social Services for children and families, Housing, MAPPA and the LIT. The LIT were concerned in particular that knowledge about risks may not be shared with the voluntary sector. Information sharing is considered further in Section 6 of this report.

Recommendations:

5.60. **The Project Board for the formation of the new Surrey and Borders Partnership NHS Trust should flag up the need for a multi agency approach to risk management to reflect the partnership working needed for the delivery of comprehensive, modern services for people with mental health problems.**

5.61. **A protocol should be developed with partner organisations for the sharing of information about patients at risk of harming themselves or others. This will require agreement from clinicians across the Trust to ensure a consistent approach.**

5.62. Our fieldwork meetings confirmed that a range of *risk assessment tools* are in use within the Trust. The CPA documentation provides a common and basic framework for the assessment of the risk patients may pose to themselves and others. This is in consistent use throughout the Trust. The tool used in the CPA process is currently under review to reflect the differences between standard and enhanced levels of CPA. However when such risks are identified a variety of tools are used in different parts of the Trust for more detailed assessment of risks. For example on Wingfield ward all patients admitted are, on arrival, subject to a risk assessment using the Galatean Risk – Screening Tool in mental health. Formal risk assessment for inpatients is thereafter an integral part of the CPA process. In Acorn the CPA risk assessment and Galatean are used. A Drug Advisory Team (DAT) requirement to use the DICES risk assessment tool which, we were told, provides a more generic assessment of risk, for service users with drug and alcohol problems, is being pursued by Acorn. Training in the use of DICES is underway and its use by Acorn is currently in the process of being cleared with the Trust.

5.63. The "Hollies" CMHT also confirmed that risk assessment is a key and integral part of the CPA process. All patients on enhanced level CPA get an initial risk assessment and the risk is re-evaluated via CPA reviews and re-assessed if changes indicate. In addition weekly CMHT meetings highlight cases of concern and they are monitored within the team. Patients on the standard level CPA may not be subject to a formal review of risk but Consultant Psychiatrists would, we were told, keep records.

5.64. Confirming that there was still an issue around risk assessment tools for the Trust, the Head of Risk Management told us that her view was that "one tool fits all" was not the way to go. The emphasis should be, she added, to keep risk assessment and review ongoing and up to date.

Comment:

5.65. *We agree with the views of the Head of Risk Management. However there is a need to ensure that the Trust is aware of and approve the use of all risk assessment tools.*

Recommendation:

5.66. **The SHB Trust and the new Surrey and Borders Partnership NHS Trust should be aware of and approve the use of all risk management tools. All risk management tools in use should be subject to regular review to ensure their continued fitness for purpose.**

Comment:

5.67. *There is good evidence from policies and from our fieldwork meetings to support the existence of a strong integration of risk assessment with the CPA process. There is no single risk assessment tool in place and there is a need for the SHB Trust and its successor Trust to be aware of and approve the use of such tools. Opportunities exist to share knowledge and experience of risk management and assessment with partner agencies and to consider whether improvements can be made in the arrangements for sharing of information about risks between agencies.*

5.68. We discussed risk assessment processes with the Head of Midwifery and the Health Visitors group. The first recommendation of the internal inquiry report into the care and treatment of CD is for the SHB Trust to "advise all relevant primary care trusts and midwifery services, that in all cases of previous severe mental illness related to pregnancy, irrespective of elapsed time, good practice would be to refer to the relevant mental health service, at the ante-natal stage, so that monitoring of the patient and a pre-birth assessment of parenting capacity and the child's needs are established in the context of risk of harm to the patient and child".

5.69. The action plan for the implementation of the recommendations of the CD internal inquiry identifies that appropriate action has been taken to put the above recommendation into action. Since these matters were raised by the representative of Blackwater Valley and Hart PCT on the SHB Trust's SUI Scrutiny Panel, there has been a process within the local Health Visiting service, re-examining the recognition and management of mental health issues.

Recommendation:

5.70. **The Blackwater Valley and Hart PCT should support Health Visiting and midwifery services in reviewing their risk assessment processes for patients presenting with a previous history of severe mental illness. The reviews should aim to ensure that clear guidelines are in place to support staff in assessing risk, using appropriate risk assessment tools and in taking decisions about onward referral to mental health services, within an appropriate clinical supervision framework.**

Incident reporting and handling serious untoward incidents (SUIs)

5.71. We reviewed the SHB Trust's policies and procedures concerning the reporting of serious untoward incidents and went on to examine the arrangements the Trust has put in place to scrutinise and monitor progress towards agreeing and implementing action plans as a result of SUI related inquiries and reviews.

5.72. The policies are clear and have been disseminated to all SHB Trust policy manual holders. This method of dissemination appears to be effective. The staff groups within the SHB Trust we met, were all aware of the procedure for reporting SUI's and where the relevant policies could be found.

5.73. We also tested in our fieldwork meetings the view of the Risk Management Committee that the reporting culture was positive. Staff groups within the Trust confirmed this to be the case.

5.74. The dissemination of the inquiry reports themselves and the subsequent action plans was not however so effective. For example the Nurse Consultant had not seen the three internal inquiry reports or the action plans nor had the Trust's former Education and Training Manager. Staff at the MBU told us that they had been advised by the SHB Trust that the report and action plan concerning the CD case was distributed on a "need to know" basis and the inference was that the manager of the MBU did not need to know. Neither the Health Visitors working in Aldershot, nor their manager were aware of the existence of the inquiry reports into the care and treatment of CD or AB or the subsequent action plans until they were approached to discuss the issues with us. Hampshire Social Services were however aware of the reports and action plans and had participated in the subsequent scrutiny processes.

Comment:

5.75. ***Whilst we understand that decisions have to be taken about the breadth and depth of dissemination of internal inquiry reports and subsequent action plans, we consider that in the interests of sharing learning, such reports or at least action plans should be disseminated as widely as possible.***

Recommendation:

5.76. **The SHB Trust and the new Surrey and Borders Partnership NHS Trust should review policy for the dissemination of internal and external inquiry and SUI review reports and associated action plans. This should aim to ensure that their use for wider shared learning, within and beyond the Trust, can be maximised. Particular attention should be paid to agreeing with partner agencies the actions they will take to disseminate information to relevant groups of staff and their managers and how they will account for implementation of actions they have agreed to take.**

5.77. Both the Nurse Consultant and the Information Governance Manager confirmed independently that recommendations arising from SUI's are fed into the Trust's clinical audit programme.

5.78. We understand that feedback on untoward incidents is provided to staff teams by the Trust's Health and Safety Advisor. Serious Untoward Incidents are reviewed at the Risk Management Committee and information is disseminated by the SUI Review Group, which includes the Locality and General Managers. Some concern was, however, expressed by managers we met, that information they provide concerning untoward incidents is not routinely fed back to them in the form of aggregated reports, except on an annual basis.

Recommendation:

5.79. The SHB Trust should consider auditing the effectiveness of feedback to mangers and staff teams concerning untoward incidents.

Comment:

5.80. ***The Trust's policy for handling SUIs is clear and well disseminated. Its scrutiny and monitoring processes for SUIs are commended. Further work is needed to improve dissemination of inquiry reports and action plans both within the SHB Trust (and its successor Trust) and within relevant partner organisations. Feedback to managers and staff groups within the SHB Trust of information analysing untoward incidents could also be improved.***

Communications at the patient care level

5.81. This sub-section deals with communications at the patient care level. Corporate communications within the SHB Trust are discussed in Paragraphs 5.121 to 5.128. below and issues concerning communications between partner agencies are considered in Section 6 below.

5.82. Communications at the patient care level were generally reported to us by staff groups and managers as being good, having improved particularly in the past two years. For example: The Acorn staff group described how their weekly team meeting had been used to disseminate information about the policy on child protection and communications with the CMHT had been improved with the nomination of a link worker from the CMHT; Acorn were members of the CPA forum which provided for good communications with colleagues across the trust on CPA issues. A locality manager explained how monthly meetings with her operational managers were progressing to spend less time on "business issues" and more on "bringing issues and learning lessons". This view was broadly supported by the managers we spoke to. We were pleased to hear from day staff at Wingfield ward that they accessed information from the range of sources available and that monthly briefings from the Modern Matron gave them access to a "wider picture of what's going on". The night staff similarly reported an improvement in communications since the Modern Matron's appointment. The CMHT, ward staff and Acorn staff all expressed satisfaction with communications between different parts of the adult mental health services about individual patients. The view of communications from the MBU (part of the SHB Trust until 1 April 2004) was less positive, perhaps because of the specialist nature of the service and the location at Basingstoke. The MBU staff mentioned the newsletter delivered with their payslips and agreed that team briefing was useful in cascading information. However they were critical about the lack of clear information about the organisation and structure of the Trust and felt that a summary, schematic description would have been helpful. Their feeling was that the information from the Trust was more focussed on the Surrey end than on Hampshire.

5.83. Communications regarding the establishment of and expectations from the new Crisis Resolution Home Treatment service were of concern to a number of the groups we spoke to. We return to this in section 6 below.

5.84. Formal communications between different component parts of the adult mental health service were also seen to have improved. Inpatient services, the CMHT and Acorn all reported for example, improvements in the timeliness of information sharing concerning admission and discharge of patients for episodes of in-patient care.

5.85. Information sharing across the acute mental health services was reported to have improved significantly since the establishment of the acute care forum as a vehicle for this purpose.

5.86. A number of the communications issues raised with us during our fieldwork meetings concerned record keeping and sharing information between different agencies. We return to these themes, including the need to develop better networking across services and between organisations, in the specialist services section below.

Specialist services

5.87. The internal inquiry reports flagged up a number of concerns about the links between the specialist services (in these cases, Acorn and the MBU) and the mainstream adult mental health services. In particular, issues around CPA, clinical responsibility, risk assessment and record keeping were raised. All these issues are picked up in the SHB Trusts post inquiry action planning process.

Acorn drug and alcohol services

5.88. The SHB Trusts SUI themed action plan for Acorn covers all the relevant recommendations from the external and internal inquiries covered in this review together with two other SUI's concerning patient's KL and MN.

5.89. On CPA the Trust were recommended to ensure that robust and effective care planning processes are utilised and understood by all staff members in Acorn.

Comment:

5.90. ***We are satisfied that the CPA is now in full use within Acorn for all patients with dual diagnosis. We also note that the dual diagnosis strategy produced by the Nurse Consultant for substance misuse/dual diagnosis and the former General Manager of Acorn is now a working document, informing and guiding staff in their work with clients with dual diagnosis. We commend the approach to and content of the strategy.***

5.91. ***Similarly, with regard to risk assessment, we are satisfied that through the use of the risk assessment documentation within CPA and via use of Galatean risk assessment, Acorn now comply with the relevant internal inquiry recommendations in this respect.***

5.92. Substantial concerns had been expressed in the internal inquiry reports about the quality of record keeping within Acorn services.

Comments:

5.93. ***We are satisfied through examination of evidence available to the SUI scrutiny panel and supported by our discussions with managers and front line staff that these concerns have been addressed and the quality of record keeping improved. This continues to be monitored on a quarterly basis as part of the ongoing clinical audit process.***

5.94. ***We have been impressed with the progress made by managers and staff within Acorn in implementing improvements recommended in the external and internal inquiries. This has required organisational and cultural change and a real willingness from staff to take change on board and learn lessons.***

5.95. It was clear from our visit to Acorn's base at Frith Cottage, Frimley that the staff team are working within the constraints of inadequate and unsuitable accommodation. The staff's view was that they are "at more risk from the building than the clients". We were told that a number of health and safety hazards had been identified. There was not sufficient room to see clients and this together with the poor quality of the accommodation impacts on the relationship between the service and its clients. We were told by the staff that the Trust had included new accommodation for Acorn on its priority list but that they (the staff) were concerned that the present level of understanding and urgency could be lost in view of the latest forthcoming Trust reconfiguration.

Recommendation:

5.96. Notwithstanding the Trust reconfiguration the new Surrey and Borders Partnership NHS Trust should continue to regard the replacement of Acorn accommodation at Frith Cottage as a very high priority.

5.97. The Acorn staff group were aware of the link between staff appraisal and personal development plans and the Trust's training and development programme. They felt however that the programme had been of limited use to them. Acorn had contributed to the Trust's range of training opportunities by setting up and running in-house training sessions related to substance misuse and dual diagnosis. The Acorn staff's perception of opportunities for personal development within the Trust was that they were limited because of under funding.

5.98. Most but not all inquiry recommendations relevant to Acorn have been implemented. However those not yet implemented or only partially implemented are clearly flagged up in the scrutiny progress with named individuals identified to take further work forward. We are confident that progress towards completing these actions will continue to be monitored.

5.99. The internal and external inquiry reports commented on the philosophy of Acorn and we heard that there had in the past been a sense that Acorn was somehow "separate to" or "apart from" the SHB Trust. Our field work confirmed that this has now changed. Acorn staff and management feel part of the Trust and other parts of the Trust report a substantial improvement in their relationships with Acorn. For example, the Aldershot "Hollies" CMHT told us that there was now no sense that Acorn was set apart from the Trust's other adult mental health services. The ward team at Wingfield ward described their working relationship with Acorn as generally good and better than in the past. They commended the "drop in service" provided by Acorn and used by in-patients, sometimes on a self-referral basis. At the management level, the General Manager of Acorn is a member of the Specialist/Locality Managers group chaired by the Interim Director of Operations.

5.100. One way in which these improvements have been achieved is by the nomination from within the Acorn team of a "link worker" who attends CMHT meetings, acts as a conduit for communications and follows up issues relating to individual patients. Another has been the provision by Acorn of a range of regular training opportunities for other interested professionals around issues relating to substance misuse and to dual diagnosis.

Comment:

5.101. ***We commend these initiatives and suggest that the "named link worker" model could be extended to facilitate improved networking, communications, liaison and joint working between other component parts of the mental health services and between mental health services and partner organisations, for example Housing Departments and MAPPA. (See section 6 below).***

The Mother and Baby Unit

5.102. The recommendations concerning the Mother and Baby Unit are all contained in the internal inquiry report into the care and treatment of AH. The subsequent agreed actions are in the action plan, considered and regularly monitored by the SHB Trust's Scrutiny Panel.

Comment:

5.103. ***From our review of the action plan and Scrutiny Panel documentation it is clear that substantial progress has been made within the Mother and Baby Unit in putting improvements in place as a result of the internal inquiry report.***

5.104. This view was confirmed for us in our meeting with MBU staff and by a review of the written response from the MBU sent by the Consultant Psychiatrist, lead clinician for the MBU to the SHB Trust Medical Director on 26 September 2003. This covered all the recommendations relevant to the MBU. Examples of such improvements include:

- Arrangements to ensure that patients are not discharged from the MBU until written and signed CPA documentation is received
- Arrangements to ensure that the patient's GP, CMHT caseworker and responsible medical officer (RMO) all get copies of the discharge summary documentation
- Invitations to CPA meetings at the MBU by telephone and by follow up letter
- Development of a new risk assessment form which is now used as part of the admission process

5.105. The MBU staff's less than positive view of communications from the SHB Trust is covered in Para. 5.82 above. Perhaps because of the geographical distance from the SHB Trust HQ and/ or because the MBU is a tertiary service operating as a regional admissions unit, it does appear that it missed out on aspects of the cascade of communications. It also missed out initially on the risk assessment training provided by the Trust and on communications about training dates.

5.106. The MBU staff told us that they never really felt part of the whole (SHB Trust) organisation. They had been part of the Trust for three years but after only one year there had been talk of the MBU moving again. Staff told us that some of them had worked at the MBU for four years and in that time they had been employed by three different Trusts.

5.107. In-service training for nursing staff was seen by MBU staff as poorly funded. This view was expressed partly in the context of issues around travelling expenses for nursing staff who needed to attend specialist conferences and courses concerned with perinatal mother and baby services.

5.108. We were impressed to hear of the range of arrangements and initiatives in the MBU to facilitate effective clinical governance. Many of these had been in place for some time and were described as well established. For example, the MBU uses regular patient/staff meetings, client surveys, staff meetings, clinical supervision in groups and or on a one to one basis and a self audit process of record keeping, ensuring that clinical governance is seen as part of the everyday work of the unit. The Clinical Director fed into the Trust's clinical governance processes through the Clinical Governance Committee.

5.109. Links with the Health Visiting services seemed very positive. The MBU staff told us that Health Visitors were usually good at feeding in "local intelligence" for example about resources and services in the locality where the patient lived. There is a named liaison Health Visitor for the MBU. She helps to ensure whenever possible that six week checks and immunisations and vaccinations are carried out in the patient's local primary care setting. She also provides valuable support in maintaining links with the respective local Health Visiting service for the individual mother and her baby. The local Health Visitors in Aldershot confirmed to us that their relationship with the MBU is good and that they get invitations to and attend CPA meetings when their clients are admitted.

5.110. The Head of Midwifery Services at Frimley Park Hospital told us that the only real link with the MBU was when a bed was needed; usually post birth. The midwifery service's first contact would be with the hospital psychiatric team at Frimley Park. They would then undertake an assessment and refer to the MBU if appropriate. In such cases, when a bed is available patients are discharged to the MBU. There are sometimes difficulties in obtaining a bed and in such cases the mother and baby are cared for at Frimley Park with CPN support until a bed is available at the MBU. The number of referrals from the midwifery service at Frimley Park Hospital to the MBU was very small; about two a year on average.

5.111. Some tensions between the MBU and child protection services were described as "inevitable". This was because child protection services were properly looking at the interests of the child whereas the MBU was often asked by the courts for reports about the ability of a mother to manage her baby.

5.112. The Consultant Psychiatrist also felt that there was still a significant problem with information sharing around child protection. He felt that this was "a one way flow". The MBU were willing to share adult mental health information but the MBU have difficulty in accessing information from child protection staff. This was seen not just as a local issue for Surrey and Hampshire but responses to requests for information from child protection services across the MBU's catchment area were not felt to be consistent. This was regarded as a particular problem for the MBU because of the number of local authority social services departments they have to deal with.

Recommendation:

5.113. Hampshire County Council Social Services Department should work with the MBU on developing an information sharing protocol which could be shared and agreed with the local authority social services departments in the catchment area served by the MBU.

Corporate issues

Corporate governance

5.114. The SHB Trust has, as an important part of its corporate agenda since April 2002, developed a structure and processes for corporate governance bringing together audit and financial control, clinical governance and risk management. Each component has a committee, chaired by a Non-Executive Director which reports direct to the Trust Board. The Clinical Governance and Risk Management committees have sub-committees to reflect the key aspects of the work and programmes of the main committee. The processes are supported by diversity champions, the Clinical Steering Board, the "engaging people" process and by the Trust's Executive Team. There is a good cross representation of membership between the various committees. For example the Trust's Director of Finance serves on both the Audit and Clinical Governance committees and the Interim Human Resources Director is a member of the Clinical Governance Committee to ensure appropriate links with the education, training and development programme.

5.115. The Trust Executive Team's view was that the structure and processes for corporate governance ensure that the clinical governance agenda is integrated into the Trust's overall objectives and is not isolated. We tested this in meetings with managers and staff at different levels and in different parts of the service. Most could identify links between their own work and practice and the Trust's clinical governance and risk management agendas. We did not specifically cover financial control and audit issues in our fieldwork but have no reason to doubt that the benefits of the Trust's integrated approach to governance are reaching the organisation at all appropriate levels.

5.116. A number of front line managers and staff mentioned to us the effectiveness of the Acute Care Forum, chaired by the Interim Director of Operations, in identifying and sharing lessons to be learned, for example from reported incidents. This type of approach, guided by the overall framework for governance was, according to the Wingfield ward management group, a factor in the Trust progressing towards a "no blame" or "fair blame" culture.

5.117. We also found that much work on governance issues was going on outside the formal integrated structure. For example the role of the Nurse Consultant in adult mental health was commented upon favourably by several of the groups we spoke to. The ability to provide expertise and advice to managers and staff about practice issues or the management of difficult individual cases outside the normal line management was clearly appreciated. The Nurse Consultant role within the Trust is seen as developmental and enabling. Similarly, within the line management arrangements, the new Modern Matron appointments were seen to have made a difference. Staff spoke to us of "things getting done quicker" and "someone who can sort out day to day problems". The Trust's Chief Executive confirmed that these people had been selected for appointment because they would be effective "agents for change".

Comment:

5.118. ***We commend the SHB Trust's approach to integrated corporate governance. A carefully developed structure together with the supporting work of "change agents" has helped to create the cultural climate from which strengths can be celebrated and problems identified and dealt with participatively and positively. We hope the hard work on this will be taken forward by the new Trust from April 2005.***

Engagement of clinicians

5.119. The SHB Trust's Chief Executive stressed to us the importance she had placed upon engaging clinicians in the strategic development and operational management of the Trust. She emphasised the importance of the "medical voice" within the organisation and the need to appreciate the pressures of being a doctor in the mental health services. There had been a history of poor relationships over the years. Improving this had been a priority over the past three years and with goodwill and hard work all round significant improvements had been achieved leading to much more positive engagement.

5.120. The group of Consultant Psychiatrists we spoke to felt that the Trust was now keen to engage doctors. The establishment of Clinical Directorates within the Trust had helped this process and they were now bedding in well. They emphasised the importance for the new Trust to implement a strong clinical directorate structure. We discussed with the Consultants a range of issues into which they were well connected. For example there is Consultant input to the LIT, a strong Consultant commitment to the clinical governance processes and engagement in risk management and risk assessment issues. The Clinical Steering Board supports the process of integrated governance. Whilst there are sometimes tensions between the mainly clinical agenda of clinicians and the sometimes "political" agenda of the Trust Board the impression we received was that those tensions are now seen as mostly "creative" rather than "negative".

Corporate communication

5.121. This section deals with corporate communication within the SHB Trust. Communications at the patient care level are discussed in paragraphs 5.81. to 5.86. above and in the "working in partnerships" section (Section 6)below which also includes aspects of communications between partner agencies.

5.122. A range of communication mechanisms are in place, including a payslip based general newsletter, "specialist" newsletters, for example the quarterly "Clinical Governance Matters" (first issue May 2004) newsletter which is sent to all staff and team briefing. All of the groups and teams we spoke to within the SHB Trust were aware of and received information through these mechanisms.

5.123. Some of the comments we received about corporate communications within the SHB Trust were as follows:

- Acorn staff group – team briefing - "language could be clearer. There is not enough "tell it like it is". "It feels spun." "There is a feedback loop via Brian (the general manager)"
- MBU staff group – team briefing - "Did cascade". "Pay packet did have a newsletter but there was not much about the Hampshire side"
- Trust Executive Team - team briefing - "There is a core briefing from the board via senior managers to staff"
- Risk Management Committee – "We are concerned to ensure that learning is disseminated. Team briefing is used as one of the mechanisms"
- Nurse Consultant – "staff are better informed over the past six months, but do people take on board the information? We don't always check out rigorously enough peoples understanding"
- CMHT – "Newsletters distributed via payslips don't get to Social Services employed staff"
- HR group – "Communications strategy is only as strong as the manager implementing it." The team briefing process needs evaluating"
- Head of Risk Management – "There has been a concern about access to information for night staff. Modern Matrons are now addressing this"
- Consultant Psychiatrists group – "The Trust is willing to engage doctors and patients and carers. Doctors feel they have a say. Lines of communication are very positive now"

- Wingfield ward day staff – "Information cascades through newsletters and monthly briefings from the Modern Matron. It gives us a wider picture of what's going on." "Yes we do read the newsletter!"
- Wingfield ward night staff (few are now on permanent night contracts, most are on an internal shift rota system) – "We feel involved in ward and Trust business." Permanent night staff receive newsletters and can attend team briefing. They also use notice boards to get information e.g. from directors' meetings. "We have access to the Modern Matron. We can ring him at home when on night duty"

5.124. The Head of Communications explained to us his role in managing the communications processes in the Trust. In addition to the mechanisms mentioned above, he told us about the use of the internet and intranet as vehicles for communication, although it had not been possible to test whether communications via these routes were received and understood. Although there is evidence that core team briefing works well in reaching staff groups there is no real clarity about how consistently it is used to add more local briefing from local managers to the core brief provided from the Board. The Head of Communications confirmed that he receives, on average, about four or five questions back through the team briefing feedback loop each month. He added that communications at the point of the launch of new Trust policies could be better. This he felt could be improved by taking information to existing staff forums.

Comment:

5.125. ***In overall terms the internal communications within the SHB Trust appear to be adequate. The core communications seem to reach all staff. Further work would be useful to check the extent to which communications are "received and understood" and to evaluate the effectiveness of team briefing in conveying corporate messages and briefing on more local issues and developments.***

5.126. ***In addition to the mechanisms specifically put in place to facilitate communication with staff, we heard, during our fieldwork meetings, about the importance of local team meetings, supervision sessions, workshops, seminars and training events in the everyday process of communication. It will be very important for the new, much larger Trust to ensure as quickly as possible that its internal communications are efficient and effective.***

Recommendations:

5.127. **The SHB Trust should initiate work to check the extent to which its core internal communications are received and understood. This could include an evaluation of the effectiveness of team briefing in conveying corporate messages, inviting and receiving feedback and briefing teams of staff on more local issues and developments.**

5.128. **The new Surrey and Borders NHS Trust should, as an early priority, ensure that internal communications across the new Trust are reviewed and evaluated and that efficient and effective internal communication processes are put in place, building on the strengths of the systems it inherits.**

Management and leadership

5.129. Our terms of reference required us to form and report a view of the management and leadership of the mental health services in the Surrey Hampshire borders area in the context of the three more recent homicides and the three earlier homicides. We therefore included in many of our fieldwork meetings, a discussion on views and perspectives of leadership and management. These discussions were very helpful to us in forming our impressions. We also looked at policy, progress, improvement, communications, management style and culture as indicators of the quality of leadership and management.

5.130. This section deals mainly with leadership and management in the SHB Trust. It has not been possible within the overall context and timescale for our work to form similar views regarding the Hampshire County Council Social Services Department or the Blackwater Valley and Hart PCT. Some commentary on leadership in the commissioning of mental health services is included in the section on working in partnership (Section 6) below.

5.131. Our overall impression of leadership in the Surrey Hampshire Borders Trust is positive. It has to be seen in the context of an unusually high degree of organisational instability due to successive service and geographical reconfigurations as described earlier in this report.

5.132. We heard reports from frontline staff of perceptions of considerable improvement, although relatively recently, (i.e. the past year or two were often mentioned), in the feeling of accessibility to senior management. For example the General Manager of Acorn drug services told us of the visits by the Chief Executive to "push forward the integration agenda". The Acorn staff expressed their appreciation of the time the Chief Executive had spent with them to learn about drug and alcohol services and her subsequent feedback through the service users' magazine. Acorn staff had not had the opportunity, however of similar interface with Non-Executive Directors of the Trust, apart from an invitation some time ago to an event at Trust headquarters. The staff at the Mother and Baby Unit, however, told us that they had no view on the Trust's leadership because it was so distant.

5.133. The CMHT felt that the local management (of the CMHT) had been excellent. They regarded the Trust Chief Executive as "very hands on and approachable". Other members of the Trust Board were not so visible and their only contact with the Trust Non-Executive Directors had been through a meeting "two years ago at Ridgewood". The CMHT also commented that they felt a sense of support rather than "scape-goating" from the organisation in cases of untoward incidents. One team member told us about his experience in one difficult case where he had not been "blamed" and was well supported in the coroners court by a manager. The CMHT described a culture in which "when we are told to do things there is the opportunity to ask why?" They also felt that when they question decisions they do get explanations and they are able to argue their point if necessary.

5.134. A similar picture emerged from our discussion with the ward management team at Wingfield ward. They reported a change in culture in the Trust to a "no blame" culture. They also highlighted the positive role of the Acute Care Forum, chaired by the Interim Director of Operations as a vehicle for positively sharing lessons. Their feeling was of improvements in culture and morale over the past two years. There was, they told us, "less divide between mangers and staff" and more working in partnership with more flexibility of management. Their perception was of increased recognition of staff contributions and of staff feeling more valued.

5.135. These views were generally reflected in our discussions with ward staff. They agreed that some managers were "good; accessible and try to listen and put suggestions into action". There was however also a comment that there is still some lack of acknowledgement of the work of frontline staff. Nevertheless their overall impression was that "there is leadership and the cascade of information works and it has got better". The ward staff emphasised that the appointment of the Modern Matron had helped. They added that their regular meetings with the Locality Manager and Interim Director of Operations also kept them in touch with wider issues in the Trust and local mental health services.

5.136. Views of the leadership and management of the SHB Trust from the "outside looking in" were not always so positive. We heard comments like: "the leadership don't seem to get anything done or have the ability to do it"; "SHB do a lot of talking but nothing seems to get done"; "SHB are very slow to appreciate the problems and apply their minds" and "the focus has been on the budget and reconfiguration and not on service development". There were also more positive comments. For example: "The trust have listened e.g. via the Acute Care Forum and resolved long term problems. There is now realistic expectation of forward movement in bite sized chunks"; "the context is instability, it would be unfair to compare with the Hampshire Partnership Trust"; "they have moved on, they have worked hard at the cultural issues".

Comment:

5.137. ***The views expressed in our fieldwork meetings confirmed our impression of the SHB Trust as an organisation having matured and made great progress in the past two years. This is also reflected in the quality of work within the Trust on putting lessons learned from SUIs into action and systematically monitoring progress. The process of culture change within the SHB Trust has clearly been significantly helped forward by the appointment and careful deployment of individual "change agents" into key organisational positions.***

5.138. ***In particular there was a significant measure of similarity in the views and perspectives we received from front line staff working in different parts of the Trust.***

5.139. ***There are clear strengths in the role within the Trust of Non-Executive directors (NEDs). For example NEDs chair committees within the integrated governance structure and chair and contribute considerably to SUI reviews and internal inquiries. However NEDs are not seen as visible or accessible to front line staff and their potential role as "ambassadors" for the Trust both internally and with partner agencies could be explored further.***

5.140. *The somewhat less positive views of the Trust's management and leadership from some other organisations are not, perhaps surprising. Cultural change in organisations takes considerable time and effort. While the improvements are now recognised within the SHB Trust by many of its own staff, the benefits for partner organisations may not yet be quite so obvious. There is, nevertheless more work for the Trust to do in explaining its work and progress on cultural change to other organisations so that they can more fully appreciate the organisational and cultural context in which change is now being managed.*

Recommendations:

5.141. The new Surrey and Borders Partnership NHS Trust should consider encouraging the establishment of a "leadership forum" with colleagues from the Social Services, Police, MAPPA, Courts Service, PCTs, Housing and other relevant services, to meet occasionally for workshop type sessions in which broader leadership and organisational issues such as culture change could be considered and shared, away from the everyday service planning or service delivery agendas.

5.142. The new Surrey and Borders NHS Partnership Trust should consider the scope for broadening the role of NEDs to provide more opportunities for their interface with front line staff and partner organisations, perhaps by introducing "lead" or "special interest" roles.

5.143. The SHB Trust and its successor should consider and explore ways to improve communications with its partner organisations and the public about the key issues, opportunities and challenges it faces.

6. Working in partnership

6.1. Previous sections have discussed the ways in which component parts of the mental health service work together and communicate. This section deals with a number of issues, arising from the internal inquiry reports and subsequent action plans, around the ways partner organisations work together. Planning, commissioning and delivery of services are discussed and sub sections are devoted to partnerships for child protection and user, carer and public involvement at the strategic and service delivery levels.

Planning and commissioning services

6.2. The differing views and perspectives we heard in relation to the planning and commissioning of mental health services suggest that there is a debate to be had locally between partner organisations about options and models.

6.3. The three cases around which this Review has been undertaken all raise issues about the planning and commissioning of services as well as how they are provided. Some of those issues clearly require a very local input to planning and commissioning. For example , in the case of AB, the need to improve the linkage between CMHT's and primary care was identified and this will need to be taken forward in the context of local needs and resources and an agreed framework within which the development of primary mental health and social care services can be planned, jointly commissioned and implemented. Other planning and commissioning issues could require a wider population needs analysis. For example in the case of CD, the need was identified to ensure that specialist services for mothers and babies develop and adhere to clear standards for referral to other mental health services and to Social Services. These are matters for the commissioners of such specialist services as well as for providers. The relatively small numbers of patients requiring such specialist services suggests the need for the planning and commissioning of such services to be undertaken on the basis of the needs of a wider population.

6.4. From a large service provider's viewpoint the SHB Trust flagged up the absence of lead and/or joint commissioning arrangements and pointed out that there was no lead PCT to which the Trust could look for a consistent approach to commissioning. In addition, because the SHB Trust's catchment area straddled two counties, there was no single commissioning process which provided consistent Social Services input into planning and commissioning.

6.5. From the Blackwater Valley and Hart PCT's perspective, it was pointed out to us that the organisational structure of the NHS Trust should not be the sole determinant of future mental health service commissioning. The PCT added that organising commissioning only on that basis would fail to reflect the complexities of mental health needs and lose opportunities to achieve improvements in the services available.

6.6. Our discussions with the Blackwater Valley and Hart PCT's interim Director of Primary Care and Planning and Partnership Manager confirmed our impression that mental health services are a strong priority for the PCT. This is partly because of a history of lack of continuity of service providers (changes in Trust configurations) and previous problems, for example in in-patient services and a comparatively under resourced CMHT serving the local area.

6.7. Notwithstanding the SHB Trust's and Social Services views concerning the difficulties of a lack of consistency in commissioning, there appears to be an acceptance all round that the Blackwater Valley and Hart PCT, in commissioning local mental health services, has positively influenced their development. For example, the Blackwater Valley and Hart PCT and Hampshire Social Services both strongly supported the SHB Trust's move to a locality management structure. This took longer to achieve than in many other parts of the country, partly because of the "two counties issue" but the commissioning process was seen as helpful to the Trust in this respect. The development of the Crisis Resolution Home Treatment service has been seen by the commissioners as a key building block in modernising services. While there have been differences of view between commissioners and the SHB Trust about the pace at which this development could be managed, there is consensus at least between the SHB Trust Board and the PCT (if not yet from across all parts of the SHB Trust) that the Crisis Resolution Home Treatment Team will be another important catalyst for change and improvement.

6.8. The commissioning process in North East Hampshire is assisted by the work of the NE Hampshire and Surrey Heath LIT. LITs were originally established to oversee the implementation of the National Service Framework (NSF) for mental health. The NE Hampshire and Surrey Heath LIT was set up in 2001. It does oversee NSF implementation and we have seen the NSF self assessment for 2003 plus progress to March 2004. Whilst it is clear that the NSF is a driver for the commissioning of services it is also apparent that the LIT has evolved into a broader planning forum. It now brings together a wide range of interested and expert individuals involved in mental health services across NE Hampshire and NW Surrey, including Housing services. The LIT has established a number of sub groups to broaden the range of expertise it can call upon and to focus on particular issues or themes. For example the Director of Housing Services for the Borough of Rushmoor is a member of the LIT and of its community sub group which has held specific meetings on housing issues. As a result the Director of Housing has accepted a lead role for the LIT for action on homelessness. She is setting up a multi agency panel to take forward these matters. A steering group includes representatives from the Social Services Department and the CMHT.

6.9. The LIT helps to prioritise issues for the localities and influence bodies involved in the LIT by for example applying pressure to PCTs and local service providers. It appears to have been an effective means of bringing issues together across PCT and county boundaries. For example, the LIT successfully supported the arguments for funding through the LDP process for the Crisis Response Home Treatment service and increasing the level of priority afforded to the development of primary care mental health services.

6.10. Members of the NE Hampshire and Surrey Heath LIT clearly think there is much work still to do. In particular they think the current focus of mental health services is too narrow and see key priorities as:

- The need to prioritise non statutory services i.e. services provided by the voluntary and private sectors
- Developing the range of community support and resources to prevent admissions and re-admissions to hospital

Comments:

6.11. ***We share the concerns of the LIT that the development of plurality in service provision and the relatively underdeveloped range of community resources need to be addressed.***

6.12. ***We accept that there are legitimate and differing views about the future shape and organisation of arrangements for planning and commissioning of mental health and social care services in North East Hampshire and North West Surrey. There is evidence of innovative and effective commissioning work in the area, facilitated by the PCTs and using the LIT as a vehicle to support the process. The logistical and organisational difficulties of ensuring that the needs of a large population, across the boundaries of two counties and served by a number of PCT's and two Strategic Health Authorities, are met in a locally sensitive, yet consistent way are not underestimated. This is a challenge facing the organisations jointly responsible for planning, commissioning and providing services.***

Recommendations:

6.13. The Blackwater Valley and Hart PCT, Guildford and Waverley PCT and Surrey Heath and Woking PCT should open discussions as soon as possible with the Surrey and Hampshire County Councils' Social Services Departments and the relevant PCTs, to explore and reach an agreement on the future arrangements for commissioning mental health services in the NE Hampshire and NW Surrey area. Such arrangements should essentially continue to recognise the needs of local populations and the diversity of provision required to meet those local needs. They should also recognise the need for a consistent overview of the mental health and social care needs of the whole population of the catchment area and how those needs should be met in the future. Commissioning arrangements should continue to build on the success of the LIT in engaging a wide range of views and expertise in the service planning process. (See also Recommendation at Para. 6.57. below regarding involving service users and carers in service planning and commissioning).

6.14. In the meantime the existing commissioners should continue to work with the SHB Trust and the new Surrey and Borders Partnership NHS Trust and other health and social care providers, towards the development of a wider range of community resources to supplement and support mental health services in the area.

6.15. Consideration should be given to the appointment of a Community Resources Development Officer for NE Hampshire and NW Surrey or a number of locality based community resource development posts.

Delivering Services

6.16. In order to examine the partnership arrangements between organisations involved with or closely interested in the delivery of mental health services in the Surrey Hampshire borders area, we included in many of our fieldwork meetings, a discussion on such partnerships and the networking needed to underpin them.

6.17. The perceptions of the NE Hampshire and Surrey Heath LIT and the Blackwater Valley and Hart PCT, with which we agree, are of a relatively underdeveloped range of community support resources for people with mental health problems in the locality. This suggests that more work is needed to develop and nurture the partnerships needed to put those resources in place and to maintain them. (See Recommendations at Paras. 6.13. to 6.15. above).

6.18. Links between the local Housing Department and the CMHT were reported by the Director of Housing and the Housing Options Manager of Rushmoor Borough Council to be very positive. Day to day informal telephone contact is often made when there are, for example problems with tenants whose behaviour may suggest a mental health problem. Social Workers or Community Psychiatric Nurses often offer support to their clients in completing housing applications. There are however no named lead or link workers identified by the CMHT or the Housing Department to facilitate closer working. Such an initiative would be welcomed by the Director of Housing Services. It could also, alongside occasional joint workshops and training events, promote a better understanding of respective roles and remits.

Recommendation:

6.19. The new Surrey and Borders Partnership NHS Trust should discuss with its partner organisations, for example Housing Authorities, and PCTs, opportunities for naming link workers to facilitate inter agency liaison and improve understanding of respective roles. For example a member of the Health Visitor team could attend meetings of the local CMHT on a regular basis and visa versa. This could also be achieved by promoting shadowing or secondment arrangements between agencies.

6.20. The Director of Housing Services also flagged up issues arising from the Government's Supporting People Programme. Locally there is, as part of the Supporting People strategy, a twice yearly inclusive forum, at which the CMHT and PCT are represented. Supporting People has allowed an extension of tenancy support from housing authorities but this has happened nationally without agreed standards, including professional standards and with no clear expectations as to outcomes. Supporting People is about support for vulnerable people in our communities. Some people who may be eligible for tenancy support may have mental health problems, but many would not meet the "severe and enduring mental Illness" criteria for CPA and receiving services from the CMHT. A "link worker" arrangement (See Recommendation at Para. 6.19. above) may help to identify individuals on the threshold of meeting the CMHT criteria and, if extended to involve primary care mental health workers, could also help with the housing/primary care/mental health services interfaces and reduce the possibility of people falling between them. This could also apply to other groups of people who are often excluded from services at present. For example: rough sleepers and people with possible mental health problems and extremely anti social behaviour.

6.21. Although the integration of mental health and social care has not been formalised in Hampshire or Surrey to form Health and Social Care (NHS) Trusts, much progress has been made on integration at the patient care, service delivery level. In the Surrey Hampshire borders area, the CMHT's work with integrated management of integrated teams. Mental health Social Workers work alongside CPN's and other mental health professionals. CMHT managers are either from a social work or a mental health service background. Integration of management continues at the Locality Manager level where again Locality Managers can be and are from either a social care or mental health care background.

6.22. We met with the Director of Commissioning for Hampshire and the Isle of Wight MAPPA (Multi Agency Public Protection Arrangements) for which the National Probation Service is the lead agency. None of the three cases subject to our review would have been likely to have met the current criteria for MAPPA. Nevertheless as this review is concerned with homicides we felt it necessary to look at the interface between the mental health services and MAPPA. The Trust Executive Team supported this view.

6.23. The purpose of MAPPA is the protection of the public. The annual report for 2002-3 for the Hampshire and the Isle of Wight MAPPA states that the Hampshire Strategic Management Board for MAPPA is responsible for ensuring that a framework is in place to manage the critically few people who live in the area and who could be dangerous to others. MAPPA engages housing, health and social services to work alongside police and probation. The Director of Commissioning explained that this collaboration will be strengthened still further by the new Criminal Justice Act which places a "duty to cooperate" on a wide range of organisations including local Health Authorities and NHS Trusts, Housing Authorities and registered social landlords, Social Services Departments and Job Centres, Youth Offending Teams (YOTs) and Local Education Authorities.

6.24. At present in Hampshire and the Isle of Wight cases are considered at meetings of Multi Agency Public Protection Panels (MAPPPs) at three levels, depending on need: One agency present; most agencies present; most agencies plus senior managers present. The intention is that all those present are involved in agreeing an appropriate approach and action and all share the risks. Senior managers attend to provide commitment across agencies to the resources needed by field staff. This includes, when needed, access to forensic psychiatric advice.

6.25. The limitation of this system is one of thresholds. MAPPA is not applied to all dangerous or potentially dangerous people. One of the criteria is concerned with offending. MAPPA criteria exclude people who have not committed criminal offences. Yet mental health professionals are often aware of people who are assessed as a potential danger to others but have not been convicted of any criminal offence. The question then arises as to how public protection services can be accessed. We are aware that this mismatch of thresholds to access the public protection arrangements on one hand and mental health services on the other has caused problems elsewhere in the country.

6.26. There have also been problems both in Hampshire and elsewhere about the sharing of information between agencies including between the mental health services, child protection services and MAPPA. The "protection joint offenders protocol" for Hampshire and the Isle of Wight was drawn up with the involvement of all relevant agencies. The NHS locally did not disagree with the process or the outcome but the sharing of patient information was a problem.

6.27. In addition the Director of Commissioning identified scope for joint work with the mental health services on risk management/assessment, where for example on hospital discharge via the CPA process the potential for re-offending is rarely, if ever, discussed with the Probation Service.

6.28. Not all of the managers we spoke to in the mental health services were aware of the existence of MAPPA.

Comment:

6.29. *The threshold problems are not restricted to Hampshire or Surrey. They are national issues. The solution in respect of dangerous or potentially dangerous people, who have not been convicted of a criminal offence, may lay in improved liaison and joint working arrangements at a level below that of MAPPA but between the same organisations involved with MAPPA.*

Recommendations:

6.30. The SHB Trust and its successor should work with MAPPA and other key agencies to develop a clearer local understanding of their respective individual and multi agency roles and perceptions, including:

- Individual organisations and multi agency roles, thresholds for services and how to access respective services
- Communications - identifying problems and opportunities in communications between agencies, including sharing of information about risks posed to others by dangerous or potentially dangerous individuals
- Identifying groups of people who do not fit neatly into existing thresholds and criteria for mental health, child protection, public protection or "supporting people" services and agreeing how those people can be supported

6.31. As a first step, a case study based, multi agency workshop should be commissioned jointly by MAPPA, the SHB Trust or its successor and Hampshire County Council Social Services department. The workshop could examine opportunities and challenges in the interface between MAPPA, adult mental health services, housing and child protection services.

Child protection and adult mental health services

6.32. A review of the themed action plan specifically relating to the recommendations concerning child protection in the AB and CD internal inquiry reports confirms that considerable progress has been made in implementation.

6.33. The process of developing, implementing and monitoring the action plan has in itself helped to promote partnership between the SHB Trust and Hampshire and Surrey County Council Social Services Department at the policy level. The Trust's CPA Development Manager and Interim Director of Operations have taken responsibility for compiling and updating the regular monitoring reports to the Trust's SUI Scrutiny Panel. There has clearly been considerable input to the process from the Social Services Department. The monitoring process is continuing. The latest report dated 19 July 2004 confirms continuing progress on all recommendations, with evidence to support achievement or partial achievement of agreed action in respect of nine of the eleven relevant recommendations. Actions to complete implementation of those not yet fully achieved and the two outstanding recommendations are recorded and named individual managers have been identified to take them forward.

6.34. We used our fieldwork meetings to test whether these achievements were reflected in a perceived improvement in partnership working at the point of service delivery.

6.35. Acorn drug service staff confirmed that they had all now attended child protection awareness training. They were clear about the overriding need to engage and sustain involvement with Social Services child protection services whenever child protection concerns were apparent.

6.36. The relationship between the Mother and Baby Unit and the child protection services is covered in Paras. 5.111. to 5.113. above. Overall the MBU staff presented a mixed picture of their experiences of working with child protection colleagues, perhaps reflecting their wide geographical catchment area and the need to work with a large number of different Social Services Departments. Whilst reporting that there were examples of good practice and good relationships, they also identified, in addition to the issues covered in earlier paragraphs, a concern about cultural sensitivity of services and to the context in which people are cared for at the MBU. The staff were not sure that these issues were always adequately recognised by the child protection services.

Recommendation:

6.37. The MBU and Hampshire Social Services child protection services should meet to discuss the issues of cultural and ethnic sensitivity of their respective services. The outcomes could form the basis of an action plan to identify and implement improvements within Hampshire which could be shared with other Social Services Departments in the MBU's catchment area.

6.38. The "Hollies" CMHT told us that the response from Social Services to referrals of child protection concerns was positive and fast. They enjoyed a good working relationship with their colleagues in Social Services based near to them in Aldershot. The response from social Services in the case of "children in need" (within the definitions of the Children Act 1989) i.e. those children in need of support but where there are no immediate child protection concerns, was however relatively slow with occasionally no response. The CMHT recognised that this was an issue about thresholds for services and giving priority to the most immediate needs; not dissimilar in principal to their own "severe and enduring mental illness" criteria.

Comment:

6.39. ***This could be one of the threshold and service access issues covered in the Workshop recommended in Paras.6.30 and 6.31 above.***

6.40. We met the County Manager (one of two) for Children and Families and the Operational Manager for the North East of Hampshire in Hampshire Social Services Department. They confirmed that there are agreed Area Child Protection Committee (ACPC) guidelines to support the relationship between Social Services and the adult mental health services. They also re-affirmed that the relationship between the services in NE Hampshire was good and had improved over the past three years. The appointment by the SHB Trust of a Locality Manager had, they felt, added impetus to the improvement. Joint meetings are held both on a large cross-service basis and also between smaller groups of local staff. It is intended to continue with joint training to maintain and improve mutual understanding of respective roles, responsibility and focus. This continuity of joint training is seen as important in view of the relatively high turnover of staff working in NE Hampshire in both child protection and the CMHT.

6.41. The County and Operational Managers also confirmed the view of the CMHT that there are different response times for referrals of child protection cases and children in need. The children and families team in Aldershot receive up to 70 referrals a day. Every referral should receive a response, but the high referral rate together with a difficulty in recruiting Social Workers in Aldershot, means that the children and families service there is under pressure. The social work team are able, however to deal with some non child protection referrals by "signposting" them to other local community services.

6.42. At the strategic level, the managers told us that joint working between Social Services and the adult mental health services has been effective in developing and implementing child protection protocols. They felt however that more work was needed with all agencies in understanding MAPPA. (See Recommendations at Paras. 6.30. and 6.31.).

6.43. Social Services had been invited to, attended and contributed to the SHB Trust's SUI Scrutiny Panel in respect of the AB and CD internal inquiry recommendations.

6.44. The Social Services managers did not see issues of record keeping and sharing information as a problem in working with the mental health services in child protection cases. This was covered by a joint information sharing agreement. We had the opportunity to examine a draft update of the document entitled "Executive Summary of the Information Sharing Protocol about Children and Young People" produced by the Hampshire Children and Young People's Strategic Partnership. The document summarises the main points of the protocol, which is an agreement between the Chief Officers of Hampshire Local Authorities, public sector agencies, (including PCTs and NHS Trusts in Hampshire and organisations involved in MAPPA), and their partner not-for profit organisations to share information lawfully and to agree standards for the benefit of the public. The protocol is the main reference document for all partner organisations, while the executive summary is intended to assist in the daily course of work with children and young people.

Comments:

6.45. ***Although we have not had the opportunity to examine the information sharing protocol itself, the executive summary is a very useful document and in particular the "flow chart" at Appendix 1 is a helpful day to day working tool.***

6.46. ***The protocol and executive summary could provide a useful basis for the recommended discussions between the Social Services Department and the Mother and Baby Unit. (See Para. 5.113. above).They could also be helpful in contributing to the recommended work on links with MAPPA. (See Paras. 6.30. and 6.31. above).***

6.47. The Social Services managers also commented upon the good relationships the children and families services have with the Mother and Baby Unit, Health Visiting service and PCTs via monthly meetings with PCT children's services lead managers.

6.48. The Wingfield ward staff told us that they were aware of the SHB Trust child protection policy and knew where to find it. They did not see any problems with sharing information in cases where child protection may be an issue. One of the clinical team leaders for Wingfield ward is designated to take a special interest in child protection and acts as a first point of advice for ward staff and managers. The staff confirmed that they attended mandatory child protection training.

6.49. The Head of Midwifery Services said that she had been aware of past concerns about mental health colleagues being somewhat reluctant to share information. They were though now "round the table" on child protection matters.

6.50. The Health Visitors based in Aldershot talked about the local child protection arrangements being "very good and with well understood processes and communications". They contrasted the tightness of the child protection system with their perception of less clear cut pathways for people with mental health problems, particularly those who may not clearly meet CMHT criteria. In further discussion however the Health Visitors identified the parallels between the adult mental health services threshold issues and those related to child protection and children in need respectively. The problem from their perspective is that Health Visitors are often left "holding" cases that just miss the criteria for other services, e.g. child protection and CMHT. The Health Visitors suggested that an extension of link workers between teams and services would be welcome. They had found this to be a useful model in their links with other services, for example those concerned with domestic violence.

Comments:

6.51. ***The views of the Health Visitors on the threshold issues are particularly pertinent as they see a very broad spectrum of cases within the universal service they offer, particularly for families with pre-school children. They echo similar comments about thresholds and the possibility of vulnerable individuals falling through them, made by a number of the people and groups we met. Representation from Health Visiting services at the workshop proposed in the Recommendation at Para. 6.31. may help to open up cross-agency dialogue about those groups of people who do not fit neatly into the thresholds and criteria for services.***

6.52. ***The suggestion about an extension of the link worker concept is followed up in the recommendation in Para.6.19. above.***

Involving service users, carers and the public

6.53. One of the four broad areas set by the SHB Trust for measuring its performance is "the experiences of people who use the services". The Trust aims to use the framework set by its "Engaging People" strategy to promote the involvement of those who use services and their carers.

6.54. Patient and public involvement (PPI) arrangements in the Trust are described by the Chief Executive as very embryonic although links are being developed with the new PPI forum.

6.55. We looked at the "working in partnership" issues around service user, carer and public involvement at the service planning and commissioning and operational service delivery levels.

6.56. In the planning and commissioning of services the LIT plays a large part in engaging a wide range of interest and expertise, particularly through its sub group structure. (See Para 6.8. above). We recognise the time and work members of the LIT continue to put into the taking issues out to users and carers' groups and to discussing them with mental health forums and voluntary groups. We accept also that staff from all relevant statutory agencies and from the voluntary sector engage in such discussions as part of their day to day work. There are nonetheless opportunities to continually explore better, more appropriate ways to engage service users and carers. Agreement between the key agencies on a strategic framework for improving such engagement could help to take this forward.

Recommendation:

6.57. **The PCTs, Social Services Departments and the SHB Trust and/or its successor should develop a strategic framework aimed at facilitating improvement in the engagement of service users and carers in the service planning and commissioning processes. This should be linked to work on exploring and agreeing future commissioning arrangements for NE Hampshire and NW Surrey. (See also Recommendation at Para. 6.13. above)**

6.58. The appointment, as recommended in Para. 6.15 above, of a Community Resources Development Officer could, apart from enabling and supporting the development of a wider range of community resources in NE Hampshire and NW Surrey, also serve to develop the involvement and partnerships needed to create and sustain those resources.

6.59. At the service delivery level there is evidence of a number of initiatives to engage and involve service users. For example: in the Acorn drugs service the user group has influenced service opening times which are now more flexible. Service users also meet with staff at "open forum" community lunch sessions. The open forums have in turn enabled the nomination of two service users to the monthly Acorn Clinical Governance and Quality Group. In addition Acorn service users produce "Up and Down" a magazine by service users for service users. It has a circulation of 150 copies a month and is funded by Acorn.

Comment:

6.60. ***We commend these initiatives as examples of how to build engagement of service issues from informal beginnings into more formal input of the perspectives and expertise of service users.***

6.61. At the Mother and Baby Unit regular patient/staff meetings are held and messages from these meetings are fed into the clinical governance forum.

6.62. Across the SHB Trust's catchment area all three CMHT's have been engaged in a conference on "recovery". This involved service users, carers and staff and was planned as an outcome of an earlier conference which brought together service users carers and mental health professionals.

6.63. The "Hollies" CMHT told us that they felt user/carer involvement to be "patchy". There were user and carer forums at Farnborough and the Ridgewood Centre but not for Aldershot. The Community Support Worker in the CMHT did however have a role in linking in with patient groups where they existed.

Recommendation:

6.64. The SHB Trust and/or its successor should work to ensure a more consistent degree of service user and carer engagement across the Trust. This should be achieved while allowing scope for local initiative and identifying opportunities for learning lessons across services from what works well and what does not.

6.65. The front line staff groups we spoke with all confirmed that patients subject to CPA in the adult mental health services are given copies of their care plan.

6.66. In our discussion with the mother of one of the homicide victims we gained a unique insight into the background leading to the tragic loss of her daughter. Mrs J also provided a number of valuable perspectives concerning partnerships between services and carers and contact after SUIs with victims' families.

6.67. IJ's mother told us that her daughter had also previously been a patient of the mental health services, though not in the period in which she lived in Aldershot or during her relationship with EF.

6.68. Mrs J's experience of the mental health services as her daughter's carer had not been positive. At the time of IJ's care in the mental health services, Mrs J had found getting information on her daughter's condition and service needs was "like getting blood out of a stone". Mrs J felt that primary carers should be able to have more information. This would help them to support their relative or the person they were caring for. It would also be of support to the carer to be aware of care and treatment plans.

6.69. Mrs J had been aware that her daughter had been involved in EF's care planning as a carer. She was however not aware of EF's diagnosis of paranoid schizophrenia until he was in prison after the fatal stabbing. Mrs J was concerned about the need to release information on patients to third parties, particularly when carers may themselves be vulnerable.

Comment:

6.70. ***Although we have not had the opportunity to look, in detail, at the issue of the release of information about diagnosis or risk in this particular case, we agree with Mrs J that there are important matters of principal regarding the release of information to carers and to third parties, particularly when carers are themselves vulnerable and/or when carers are also users of the mental health services.***

Recommendation:

6.71. **The questions of when and in what circumstances, information should be released to carers or other third parties, how this should be decided and by whom, should be considered by the mental health services and partner agencies. This could form part of the wider joint discussions recommended in Paras. 6.30. and 6.31. above.**

6.72. Mrs J told us about the support provided for service users like EF by a soup kitchen in Aldershot. She felt that there should be more support for such "informal" services and for the dedicated people who run them. (See also Recommendations at Paras. 6.14. and 6.15. above).

6.73. In the period immediately after her daughter's tragic death, the attention and support from the police was, Mrs J told us, "very very good". They later talked Mrs J through the whole trial process and collected her and provided transport to and from the court. Staff from Willow House in the mental health services had also been to see Mrs J. Support from Victim Support had not been as positive. Mrs J's other daughters had asked for support from a female Victim Support worker but were offered support from a male worker two months later.

Comment:

6.74. ***We were most grateful to Mrs J for being prepared to talk to us about such a painful time in her life. The insights and background information she was able to provide were of considerable help in the Review.***

7. Summary of Recommendations

Note: This summary is set out in groups of recommendations to identify the addressee for each recommendation. With effect from 1 April 2005 the Surrey Hampshire Borders NHS Trust has merged with two other mental health Trusts in Surrey to form the new Surrey and Borders Partnership NHS Trust. Implementation of recommendations in this report for the SHB Trust will now be the responsibility of the Surrey and Borders Partnership NHS Trust.

Recommendations addressed to Surrey and Borders Partnership NHS Trust

7.1. The SHB Trust's SUI Scrutiny Panel should, at the earliest opportunity, highlight each agreed action not yet addressed or partially completed. The Panel should formally agree a timetable, responsible organisation and responsible officer for each "non-completed" action to be implemented with a target date for completion. Any difficulties in meeting agreed timetables should be discussed by the Scrutiny Panel chairman with the Chief Executive of the responsible organisation. (Para. 4.48. Page 30)

7.2. The SHB NHS Trust should review the arrangements for scheduling CPA meetings to allow for a longer period of notice of the meeting time and date for those invited to attend. (Para. 5.33. Page 39)

7.3. The SHB Trust should examine ways of forging closer links between CPA and the patient risk management process. Particular attention should be given to the need to build in appropriate risk assessment tools to the CPA process. This should aim to ensure that risk assessment is confirmed as an integral part of CPA and may help to overcome any remaining views of CPA as a "bureaucratic paper exercise". (Para. 5.45. Page 43)

7.4. The SHB Trust should ensure that the training of medical staff in assessment, through their participation in CPA training, is implemented as soon as possible. (Para. 5.49. Page 45)

7.5. The SHB Trust should ensure that the responsibilities of the Executive Director (the Interim Director of Operations) responsible for CPA are outlined in the job description for that post as soon as possible. (Para. 5.50. Page 45)

7.6. The SHB Trust, through the Risk Management Committee, should consider ways of clarifying the threshold for reporting "near misses", perhaps through a workshop involving staff and managers from different levels and a cross section of the Trust's services. (Para. 5.56. Page 47)

7.7. The Project Board for the formation of the new Surrey and Borders Partnership NHS Trust should flag up the need for a multi agency approach to risk management to reflect the partnership working needed for the delivery of comprehensive, modern services for people with mental health problems. (Para. 5.60 Page 47)

7.8. A protocol should be developed with partner organisations for the sharing of information about patients at risk of harming themselves or others. This will require agreement from clinicians across the Trust to ensure a consistent approach. (Para. 5.61 Page 48)

7.9. The SHB Trust and the new Surrey and Borders Partnership NHS Trust should be aware of and approve the use of all risk management tools. All risk management tools in use should be subject to regular review to ensure their continuing fitness for purpose. (Para. 5.66. Page 49)

7.10. The SHB Trust and the new Surrey and Borders NHS Partnership Trust should review policy for the dissemination of internal and external inquiry and SUI review reports and associated action plans. This should aim to ensure that their use for shared leaning, within and beyond the trust, can be maximised. Particular attention should be paid to agreeing with partner agencies the actions they will take to disseminate information to relevant groups of staff and their managers and how they will account for the implementation of actions they have agreed to take. (Para. 5.76 Page 52)

7.11. The SHB Trust should consider auditing the effectiveness of feedback to managers and staff teams concerning untoward incidents. (Para. 5.79. Page 53)

7.12. Not withstanding the Trust reconfiguration, the new Surrey and Borders Partnership NHS Trust should continue to regard the replacement of Acorn accommodation at Frith Cottage as a very high priority. (Para. 5.96. Page 57)

7.13. The SHB Trust should initiate work to check the degree to which its core internal communications are received and understood. This could include an evaluation of the effectiveness of team briefing in conveying corporate messages, inviting and receiving feedback and briefing teams of staff on more local issues and developments. (Para. 5.127. Page 68)

7.14. The new Surrey and Borders Partnership NHS Trust should, as an early priority, ensure that internal communications across the new Trust are reviewed and evaluated and that efficient and effective internal communication processes are put in place, building on the strengths of the systems it inherits. (Para. 5.128. Page 68)

7.15. The new Surrey and Borders Partnership NHS Trust should consider encouraging the development of a "leadership forum" with colleagues from social services, MAPPA, courts service, PCTs, housing and other relevant services, to meet occasionally, for workshop type sessions in which broader leadership and organisational issues such as culture change could be considered and shared, away from the everyday service planning or service delivery agendas. (Para. 5.141. Page 72)

7.16. The new Surrey and Borders Partnership NHS Trust should consider the scope for broadening the role of NEDs to provide more opportunities for their interface with front line staff and partner organisations, perhaps by introducing "lead" or "special interest" roles. (Para. 5.142. Page 72)

7.17. The SHB Trust and its successor should consider and examine ways to improve communications with its partner organisations and the public about the key issues, opportunities and challenges it faces. (Para. 5.143. Page 72)

7.18. The new Surrey and Borders Partnership NHS Trust should discuss with its partner organisations, for example Housing Authorities and PCT's, opportunities for naming "link workers" to facilitate inter agency liaison and improve understanding of respective roles. For example a member of the Health Visitor team could attend meetings of the CMHT on a regular basis and visa versa. This could also be achieved by promoting shadowing or secondment arrangements between agencies. (Para. 6.19. Page 80)

7.19. **The SHB Trust and its successor should work with MAPPA and other key agencies to develop a clearer understanding of their respective individual and multi agency roles and perceptions, including:**

- **Individual organisations' and multi agency roles, thresholds for services and how to access respective services**
- **Communications - Identifying problems and opportunities in communications between agencies, including sharing of information about risks posed to others by dangerous or potentially dangerous individuals**
- **Identifying groups of people who do not fit neatly into existing thresholds or criteria for mental health, public protection, or "Supporting People" services and agreeing how those people can be supported (Para. 6.30. Page 83)**

7.20. **As a first step, a case study based, multi agency workshop should be commissioned jointly the SHB Trust or its successor, MAPPA and Hampshire County Council Social Services Department. The workshop could examine opportunities and challenges in the interface between MAPPA, adult mental health services, housing and child protection services. (Para. 6.31. Page 83)**

7.21. **The SHB Trust and/or its successor should work to ensure a more consistent degree of service user and carer engagement across the Trust. This should be achieved while allowing scope for local initiative and identifying opportunities for learning lessons across services from what works well and what does not. (Para. 6.64. Page 92)**

7.22. **The questions of when and in what circumstances, information should be released to carers or other third parties, how this should be decided and by whom, should be considered by the mental health services and partner agencies. This could form part of the wider joint discussions recommended in Recommendations 7.19. and 7.20. above) (Para. 6.71. Page 93)**

Recommendations addressed to Primary Care Trusts

7.23. The Blackwater Valley and Hart PCT should support Health Visiting and Midwifery services in reviewing their risk assessment processes for patients presenting with a previous history of severe mental illness. The reviews should aim to ensure that clear guidelines are in place to support staff in assessing risk, using appropriate risk assessment tools and in taking decisions about onward referral to mental health services, within an appropriate clinical supervision framework. (Para. 5.70 Page 50)

7.24. The Blackwater Valley and Hart PCT, Guildford and Waverley PCT and Surrey Heath and Woking PCT should open discussions, as soon as possible, with the Surrey and Hampshire County Councils' Social Services Departments to explore and reach agreement on the future arrangements for commissioning mental health and social care services in the NE Hampshire and NW Surrey area. Such arrangements should essentially continue to recognise the needs of locality populations and the diversity of provision required to meet those local needs. They should also recognise the need for a consistent overview of the mental health and social care needs of the whole population of the catchment area and how those needs should be met in the future. Commissioning arrangements should continue to build on the success of the LIT in engaging a wide range of views and expertise in the service planning process. (See also Recommendation 7.27. below regarding involving service users and carers in service planning and commissioning.) (Para. 6.13. Page 78)

7.25. In the meantime the existing commissioners should continue to work with the SHB Trust and the new Surrey and Borders Partnership NHS Trust and other health and social care providers, to produce a strategy for the development of a wider range of community resources to supplement and support mental health services in the area. (Para. 6.14. Page 78)

7.26. Consideration should be given to the appointment of a Community Resources Development Officer for NE Hampshire and NW Surrey or a number of locality based community development posts. (Para. 6.15. Page 78)

7.27. The PCT's , Social Services Departments and the SHB Trust and /or its successor should develop a strategic framework aimed at facilitating improvement in the engagement of service users and carers in the service planning and commissioning processes. This should be linked to work on exploring and agreeing future commissioning arrangements for NE Hampshire and NW Surrey. (See also Recommendation 7.24. above). (Para. 6.57. Page 91)

Recommendations addressed to Hampshire County Council Social Services Department and the Hampshire Partnership NHS Trust

7.28. Hampshire County Council Social Services Department should work with the Mother and Baby Unit on developing an information sharing protocol which could be shared and agreed with the Local Authority Social Services Departments in the catchment area served by the MBU. (Para. 5.113. Page 62)

7.29. The MBU and Hampshire Social Services child protection services should meet to discuss the issues of cultural and ethnic sensitivity of their respective services. The outcomes could form the basis of an action plan to identify and implement improvements within Hampshire which could be shared with other Social Services Departments in the MBU's catchment area. (Para. 6.37. Page 85)

Appendix A

Strategic Health Authority

Report to:	HAMPSHIRE & ISLE OF WIGHT STRATEGIC HEALTH AUTHORITY and BLACKWATER VALLEY & HART PRIMARY CARE TRUST
Title:	SUMMARY OF PROPOSAL IN RESPECT OF RECENT MENTAL HEALTH HOMICIDES AT SURREY HAMPSHIRE BORDERS NHS TRUST
Author:	Ed Marsden and Barry Morris, Verita Inquiry Consultancy, Richard Samuel, Assistant Chief Executive
Lead Director:	Richard Samuel, Assistant Chief Executive
Purpose:	This paper is for approval by both the Hampshire and Isle of Wight Strategic Health Authority Board and the Blackwater Valley and Hart Primary Care Trust Board
Decision Sought:	The Board are asked to approve the following: • The commissioning of this review along the lines set out in sections 2 and 3; and the likely cost and timetable. and note that reports about progress on this work will be brought to future board meetings, within the private agenda.

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1. BACKGROUND

Surrey Hampshire Borders NHS Trust (SHB) has had three mental health homicides (EF, AB and CD) in the course of the last two years. All three have been the subject of internal investigations and action plans. SHB Trust and Hampshire County Council have commissioned these investigations jointly. And the Trust and the County Council are taking steps to ensure that service improvements identified by these reviews are being made. During the same period the Trust has also been implementing the recommendations of an earlier independent inquiry report into the care and treatment of ML, PH and CM published in July 2001.

The Strategic Health Authority and Blackwater Valley & Hart Primary Care Trust met the Trust and Hampshire County Council on 22 May and 29 July to discuss these incidents, the response to them and any further action that is needed given the serious nature of these incidents. During these discussions account has been taken of the following:

- The views of families and relatives in the aftermath of these incidents, in so far as they are currently known, including the mother of EF's victim who has been in correspondence with the SHA about whether an independent inquiry is to be commissioned into his care & treatment

- Any comment/criticism made about NHS care & treatment during legal proceedings

- Any significant media comment about these cases; and

- The provisions of HSG (94) 27 *Guidance on the discharge of mentally disordered people and their continuing care in the community,* which is the NHS guidance under which mental health homicide inquiries are commissioned. The policy is in the process of being revoked but is at the moment still in force

The conclusion is that, while these cases should prompt a further review, this would not take the form of a traditional independent homicide inquiry. Instead the further work would be focussed on organisational learning and service improvement

2. PROPOSAL

It is therefore proposed that an external review is commissioned by the SHA and Blackwater Valley & Hart PCT to examine the broad underlying causes of each of these three incidents and to review in general terms the progress on implementing the recommendations of the earlier independent inquiry. This review will not, however, take the form of a traditional mental health inquiry. Rather, it will pursue a less adversarial, more collaborative approach, which will seek to address *why* the incidents occurred rather than simply *what* happened. It is anticipated that this approach will result in greater learning and hence service improvement. The core questions the review will be expected to address are:

- Are the systems & processes in place to prevent incidents of this sort happening again?
- Have services and practitioners adapted their practises in the light of these incidents and the subsequent reports?

The external review will result in a rigorous, independent (and therefore defendable) piece of work that would look at the incidents and the responses to them, the mental health service and the trust's governance arrangements. The work will be carried in two phases as set out below.

Given the proposed reconfiguration of mental health services – including the dissolution of SHB Trust in March 2004 – the external review will report, not only to the commissioners of the review but also to the project board overseeing the organisational changes in mental health services. A non-executive director in the new organisation will also be identified to oversee the implementation of the recommendations arising from the work. This will ensure that this important work is not overlooked at a time of considerable organisational change.

Phase 1

Review of actions in relation to the original independent inquiry report and the recent internal inquiries into the care & treatment of EF, AB and CD. In particular the review should consider:

- Why these three further incidents occurred e.g. human error in a weak system, sub-optimal service or wayward individual practitioner
- The robustness of the three internal inquiries and whether the recommendations contained in them were an adequate response to the findings
- Whether the action plans for these reviews actually satisfy the recommendations
- To what extent the action plans have been implemented; and
- Whether the changes have been absorbed into the culture of the organisation and the lessons understood and learned

The review group will also consider what progress the Trust has made implementing the recommendations of the earlier independent inquiry. This should be a general review rather than a detailed analysis of progress.

Phase 2

The second phase of the work will require the reviewers to look at broader organisational issues relevant to these incidents. The reviewers will not be expected to explore all the issues in depth but simply in sufficient detail to place these incidents in the context of the important organisational systems and processes i.e. to establish whether or not weak systems permitted these incidents to happen (or were a major contributory factor).

The issues will include:

- Mental Health Services

  - Implementation and application of CPA – including documentation & record-keeping;
  - Approach to risk management and risk assessment;
  - Application of clinical audit;
  - Approach to and support for clinical governance;
  - Incident reporting arrangements;
  - Integration with social care – progress with organisational & operational integration;
  - Education, training and CPD;
  - Service user and carer involvement (especially in individual care plans);
  - Complaints;
  - Staff survey;
  - Communications – between different parts of the mental health/drug services and with the corporate Trust;
  - Management & leadership – including clinical leadership; and
  - Information systems.

- Corporate Trust

  - Clinical governance – including capacity & resources
  - Internal performance management of mental health services – including information available to support this task
  - Engagement of clinicians in management
  - Corporate & directorate communications – especially given multiple sites
  - Integration with social care; and
  - Board oversight of quality of care.

In conducting the work, the review will need to take account of other important associated work commissioned by both the PCT and Surrey Drug Action Team (DAT). This includes:

- The independent review of the SHB Acorn Substance Misuse Team; and

- The HAS modernisation review of SHB Trust

The terms of reference and reports from the above reviews will be shared with the review team.

While this will be a complex and wide-ranging review it should be borne in mind that the investigation follows the deaths of individuals at the hands of those in the care of NHS mental health services and it is important that lessons are learned.

The outcome of the external review will be made public. The decision about the timing and nature of this will be made by the SHA and PCT, taking account of the views of families/relatives and the review team.

3. CONDUCT OF THE REVIEW

A small, multidisciplinary team will carry out the review – some necessary skills and attributes are listed in Appendix 1. The team ought to be sufficiently independent of local services to reach an independent and objective judgement about this matter. They also need to be appropriately senior and experienced to deal with the complexities of the work. The SHA and PCT - with assistance from Verita - will be responsible for selecting and briefing the review team about the task and agreeing with them the approach. This will help direct and quality assure the review but is not intended to trespass on the independent judgement of the team. Verita will also assist in reviewing the draft report with the SHA and PCT. (The Department of Health are keen to see independent inquiries and reviews routinely quality assured by SHAs and PCTs.)

The team will also need to work with Hampshire County Council in order to bring in the social care dimension of these cases (HCC being the joint commissioner of the recent internal reviews into EF, AB and CD).

The likely component parts of the review are as follows:

- Briefing of external review team including discussion about: background, terms of reference, approach to work, timetable and logistics including administrative support
- Agreement of team roles & responsibilities – including who will write the report
- Document review
- Fieldwork – including discussions with clinical & other staff (the fieldwork is best directed and managed through an agreed work programme as this ensures that each topic is explored in appropriate detail)
- Drafting of report including involving those who have participated in the review contributing to the development of recommendations
- Presentation of findings and recommendations to SHA, PCT, Trust and HCC
- Publication of the outcome of the work; and
- Preparation and presentation of development plan by Trust

The review team will be asked to make a monthly progress report to the SHA and PCT about the progress of the work. A timetable for the review will be produced after the briefing meeting.

4. OUTCOMES AND OUTPUTS

The successor organisation to SHB Trust will be responsible for producing a development plan in response to the review's recommendations. Implementation of this will be led by a Trust non-executive director and monitored as part of the PCT's regular performance management of the new Trust.

5. VIEWS OF RELATIVES AND OTHER INTERESTED PARTIES

This approach has received support from the Department of Health Inquiries and Investigations Unit. Meetings have also been held with some of the involved relatives and they are also content with what is proposed and would like to be kept informed of progress.

6. TIMETABLE

The work will commence in the late 2003 or early 2004 and should take approximately 20 to 25 days to complete.

7. COSTS

The review will probably cost in the region of £80k – assuming the review panel comprises three external (rather than seconded) individuals. (It should be noted that this will be approximately one third the cost of an alternative approach, which would be to commission one large or three small-scale independent mental health homicide inquiries.)

8. SHA MANAGEMENT OF REVIEW

Assuming this proposal, that includes the terms of reference, which is being considered under the Part 2 business agenda is accepted, the SHA and the PCT's initial responsibility will be to agree the panel members, the remit, the timetable and the costs.

Thereafter they will need to:

- Receive regular interim reports from the panel – initially to management and for onward reporting to the full Board
- Ensure that the report meets the expected standard of quality
- Control the communication process with family relatives
- Ensure the internal communication for all parties involved, particularly staff, is appropriate
- Establish a multi-organisational communications team to develop a communications strategy for this review
- Ensure that the full report is shared with the relatives and with the organisations concerned and also on a confidential basis share the report with specific clinicians who were involved in providing direct care to individuals associated with this review
- Ensure that the final report, with key issues highlighted, goes to full Board along with the executive summary and recommendations and the action plan. At this point it is envisaged that the report will be made public, however a decision will be made following the outcome of the findings of the review and discussion with the families in order that their views and wishes can be respected
- Agree on the timing and nature of publication of the report and then co-ordinate the publication
- Ensure that a development plan is drawn up by the successor organisation to the SHB Trust
- Liaise with the PCT over performance management of that plan

Appendix 1

1. Panel membership

Skills and attributes of panel members

Seniority:

Must be able to demonstrate an ability to deal comfortably with Chief Executives, Directors and Boards.
'Deal' in this context means communicate, be authoritative, not afraid to challenge at highest levels, but understanding of the realities of the roles and responsibilities of these individuals.

Management ability:

A "big picture" person

Specifically in this context, the ability to examine and understand organisational issues and the pressures that constant change can bring both to the organisations and individuals concerned.

Facilitative skills:

The approach to be adopted with this review will require meetings to be convened and then more importantly, facilitated. These will probably include senior people who may be uncomfortable, more junior people may feel disempowered and others who are simply unused or unwilling to speak up in meetings. For the review to be successful, these collaborative meetings will need to skilfully run to ensure the 'why?" question is addressed.

Specialist knowledge:

An understanding of current standards of good practise in mental health services will be important.

Other points:

- Panel members should not be local people – too great a potential for conflict of interests, plus the need to not only be independent but be seen to be independent
- Panel members should be able to embrace the ‘working with’ approach rather than the ‘inquiring of..’ approach
- Roles and responsibilities of individual members of panel will need to be agreed, but it may not be necessary to formally designate a chair. May be some benefit in modelling the collaborative approach
- One member should be a ‘lay’ person. This will bring a non-NHS viewpoint to the review, and should instinctively focus on both the families involved and the view of the media/general public

Appendix B

Bibliography and List of Documents Examined

Care Programme Approach (CPA)

Apr 1996 — Heathlands Mental Health NHS Trust & Surrey and Hampshire Social Services:
Policy for the Care Programme Approach and Hospital Discharge Procedures

2000 — North Hampshire, Loddon Community NHS Trust; Surrey Hampshire Borders NHS Trust & Surrey and Hampshire County Council Social Services Departments:
Care Programme Approach – Overarching Operational Policy

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Care Programme Approach – Overarching Operational Policy (revised)

Jan 2004 — Surrey Hampshire Borders NHS Trust & Surrey and Hampshire County Council Social Services Departments:
Care Programme Approach – Overarching Operational Policy (reviewed without amendment)

-- — NHS Executive & SSI:
Effective Care Co-ordination in Mental Health Service – Modernising the Care Programme Approach
A Policy Booklet

Risk Management and Risk Assessment

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The Home Office Mental Health Unit and its Approach to the Assessment and Management of Risk

Sept 1999 — Morgan, S. & Hemming, M., Mental Health Care Vol. 3, No. 1:
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Power Play

Mar 2000 — Coyne, A., Mental Health Practice Vol. 3, No. 6:
Ethical, Legal and Aspects of Risk Assessment

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Risk and Scapegoating

Nov 2002 — Surrey Hampshire Borders NHS Trust:
Risk Management Strategy

2003 — Surrey Hampshire Borders NHS Trust:
Risk Register 2004

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Risk Management Strategy

Jan 2004 — NHS Litigation Authority:
Clinical Negligence Scheme for Trusts – Risk Management Standards Report of Assessment

Jan 2004 NHS Litigation Authority:
Risk Pooling Schemes for Trusts – Risk Management Standards Report of Assessment at Level 1

--- Britten L., Isle of Wight Healthcare; Coulson, A., Portsmouth Healthcare; Hillier T., West Hampshire NHS Trust & Swyer B., Hampshire Social Services/Hampshire Probation Services:
Competency Standards for Clinical Risk Assessment and Management

--- Risk Assessment, Management and Audit System (RAMAS):
Manual

Record Keeping

Nov 2002 Surrey Hampshire Borders NHS Trust:
Interagency Policy on Confidentiality and the Management of Service User Information

Dec 2002 Surrey Hampshire Borders NHS Trust:
Guidelines for Clinical Record Keeping

Feb 2003 West Hampshire NHS Trust; Hampshire Social Services Department; Southampton Social Policy Directorate & Surrey Hampshire Borders NHS Trust:
Staff Practice Guidelines for Confidentiality and Information Sharing

Feb 2003 Surrey Hampshire Borders NHS Trust; West Hampshire NHS Trust; Hampshire County Council & Southampton City Council:
Procedural Agreement Between the Agencies on Arrangements for the Transfer and Management of Confidential Service User Information

June 2003	North West Surrey Mental Health Partnership Trust; Surrey Hampshire Borders NHS Trust & Surrey County Council Social Services: Procedural Agreement Between the Agencies On Arrangements for the Transfer and Management of Confidential Service User Information
Oct 2003	Surrey Hampshire Borders NHS Trust: Wingfield, ICU, Noel Lavin Unit Acute Wards Record Keeping Standards Audit

Incident Reporting and Handling

Serious Untoward Incidents (SUIs)

July 2001	North & Mid Hampshire Health Authority & Hampshire County Council Social Services Department: Report of an Independent inquiry into the Care and Treatment of M.L., P.H., and C.M.
June 2002	Surrey Hampshire Borders NHS Trust & Hampshire County Council Social Services: Report of an Internal Inquiry into the Care and Treatment of "AB"
Aug 2002	Surrey Hampshire Borders NHS Trust & Hampshire County Council Social Services: Joint Internal Investigation regarding "CD"
Oct 2002	Surrey Hampshire Borders NHS Trust: Overarching Report of an Internal Inquiry into the Care and Treatment of "AB, MN and KL"
Dec 2002	Surrey Hampshire Borders NHS Trust: Untoward Incident Policy (Incl. Procedure for Serious Untoward Incidents)

Feb 2003 Surrey Hampshire Borders NHS Trust & Hampshire County Council: Joint Internal Review of the Care and Treatment of "EF"

Communications at the Patient Care Level

Specialist Services -
Acorn Drug and Alcohol Services

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Policy for Pregnant Drug and Alcohol Users

Sep 2003 CHYP Mental Health Audit:
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July 2004 Hampshire, Portsmouth and Southampton Social Services Departments & Relevant Health Trusts:
Joint Working Protocol - Mental Health, Substance Misuse and Child Care

Mother and Baby Unit (MBU)

Corporate Governance

Clinical Governance

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April 2002	Surrey Hampshire Borders Mental Health and Learning Disability NHS Trust: Clinical Governance in 2002/2003 – Draft One
2003/2004	Surrey Hampshire Borders NHS Trust: Clinical Governance Development Plan 2003/2004
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Education and Training

--	Surrey Hampshire Borders NHS Trust: Training and Development Guidelines

Engagement of Clinicians

Roles of Clinicians

May 2004	Surrey Hampshire Borders NHS Trust: Report to Trust Board on Consultant Contract

Corporate Communication

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Apr 2004	Surrey Hampshire Borders NHS Trust: Newsletter Issue No. 43
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Controls Assurance

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June 2004	Surrey Hampshire Borders NHS Trust: Statement of Internal Control 2003/4

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2002/2003	Hampshire Constabulary & National Probation Service for England and Wales (Hampshire): Hampshire and Isle of Wight Multi-Agency Public Protection Arrangements
---	Hebenton, B. & Thomas, N., Introducing Lay People into Multi-Agency Public Protection Arrangements – A Pilot Study of Eight Areas

In-patient Services

Aug 2003	Surrey Hampshire Borders NHS Trust: Wingfield & Ridgewood Centre & Noel Lavin Acute Unit Farnham Road Hospital Acute Services Admission Audit
---	Health & Social Care Advisory Service: National Service Framework Standards for Acute Psychiatric In-Patient Care for Blackwater Valley and Hart PCT

Other

Mar 2003	Surrey Hampshire Borders NHS Trust: Engaging People Strategy – Final Draft
Sept 2003	Health and Social Care Advisory Service: Review of Adult Mental Health Services and a Proposed Three Year Mental Health Strategy for Blackwater Valley and Hart Primary Care Trust and Surrey Hampshire Borders NHS Trust
Jan 2004	NHSP Research & Information: National NHS Staff Survey 2003 – Surrey Hampshire Borders NHS Trust (Larger Sample)
Feb 2004	Royal College of Psychiatrists; NHS Modernisation Agency; NHS National Institute for Mental Health in England; Department of Health & British Medical Association: New Roles for Psychiatrists
July 2004	Hart District Council; Rushmoor Borough Council & Supporting People: A Directory of Housing Support Schemes in Rushmoor and Hart

Appendix C

Individuals and groups who met the review team

"Open Door" Question and Answer Session – open to all SHB NHS Trust staff.

SHB NHS Trust Executive Group

SHB NHS Trust Risk Management Committee

SHB NHS Trust Clinical Governance Committee

Brian Palmer - General Manager – Acorn Drug and Alcohol Services – SHB NHS Trust

Dr Paul Van der Bosch – GP Prescribing Adviser- Acorn Drug and Alcohol Services

Julie Smith – Nurse Consultant – SHB NHS Trust

Mrs J – Mother of IJ, a homicide victim

Specialist and Locality Managers Group – SHB NHS Trust

Helen Wingrave – CPA Development Officer – SHB NHS Trust

Liz McGill – Locality Manager SHB Trust

Ward Management Team – Wingfield Ward –Ridgewood Centre- SHB Trust

Marjorie Guest – Head of Risk Management –SHB NHS Trust and Jean Loftus – Complaints Advisor- SHB NHS Trust

Aldershot Community Mental Health Team

Dr Olive Fairburn – General Practitioner (PCT Mental Health Lead) – Blackwater Valley and Hart PCT

Acorn Drug and Alcohol Service – Staff Team

Diana Dunsford – Head of Medicines Management- Blackwater Valley and Hart PCT and Fiona Bandari – Pharmacy Advisor – Blackwater Valley and Hart PCT

Jane Milton – Locality Manager and Sarah Baines – Nurse Consultant - Drug and Alcohol Services – Hampshire Partnership NHS Trust

Gavin Wright – Former Human Resources Director , Nick Tanner – Acting HR Director , Karen Clements – Learning and Development Manager and Linda Herbert – former Learning and Development Manager – all SHB NHS Trust

Marilyn Saker – Head of Midwifery Services, Frimley Park Hospital NHS Trust

Barbara Swyer – Director of Commissioning, Hampshire Multi Agency Public Protection Arrangements (MAPPA)

Dr. M Hawthorne – Medical Director SHB NHS Trust, Dr Shoeb – Clinical Director, Adult Mental Health Services, SHB NHS Trust, Dr Best – Consultant Psychiatrist, Dr Rushton – Consultant Psychiatrist

Jill Stannard – Assistant Director, Adult Services; Graham Collingridge- County Manager, Strategy and Ruth Dixon – County Manager, Mental Health Operations, Hampshire County Council Social Services
Kate Hart – County Manager, Children and Families and Lynn Ludford – Operational Manager, Family Support/ Children in Need, Hampshire County Council Social Services

Helen Clanchy – Interim Director of Primary Care and Nick Buchanan – Planning and Partnership Manager, Blackwater Valley and Hart Primary Care Trust

North East Hampshire and Surrey Heath Local Implementation Team (LIT)

Mother and Baby Unit Staff Group, Parklands Hospital, Basingstoke; Hampshire Partnership NHS Trust

Patrick McCulloch – Head of Communications, SHB NHS Trust

Day Staff Group, Wingfield Ward, Ridgewood Centre

Night Staff Group, Wingfield Ward, Ridgewood Centre

Health Visitors Group, Aldershot

Alison Whitely – Director of Housing and Suzanne Hellicar – Housing Options Manager, Rushmoor Borough Council

Fiona Green – Chief Executive, SHB NHS Trust

Amanda Roberts-Edney – Manager Crisis Response Team SHB NHS Trust

Crisis Response Team Members Group