VERITA

IMPROVEMENT THROUGH INVESTIGATION

Assurance report reviewing progress in response to recommendations made in the independent review into the care and treatment of Ms A

A report for NHS England (North-West Region)

February 2024

Author:
Kieran Seale

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for regulated organisations.

Verita
338 City Road
London EC1V 2PY

Telephone 020 7494 5670

E-mail enquiries@verita.net
Website www.verita.net

Contents

1. Introduction

The incident

1.1 Ms A killed the victim, a child who had no connection to her, on 22 March 2020. Ms A subsequently pleaded guilty to manslaughter on the grounds of diminished responsibility. Ms A had been a patient of a mental health NHS foundation trust ('the trust') before the incident.

1.2 In March 2021 NHS England North-West Region commissioned Verita to carry out an independent review of Ms A's care and treatment under the NHS Serious Incident Framework (2015). We were assisted in the review by an expert who is the chief medical officer at The Huntercombe Group and Active Care Group, and a former clinical director at Broadmoor High Secure Hospital.

1.3 The terms of reference for the independent review said that there should be an assurance follow-up review twelve months after the report had been published to independently assure NHS England and the commissioners that the report's recommendations had been fully implemented.

Approach to this review

1.4 This independent quality assurance review utilises evidence provided by the trust on the actions that they have taken since our initial review. A list of the evidence reviewed is shown in appendix A.

2. The Verita independent review

2.1 The trust carried out an internal investigation which was completed in October 2020. Verita's independent review began in March 2021 with the final report published in May 2022.

2.2 The Verita review identified the main events in Ms A's care and treatment as follows:

- November 2014 – Ms A was first referred to the mental health trust by her GP. She was treated as an outpatient.
- July 2015 - Following an incident when she was found holding a knife and expressing anxiety that she was being harmed by her neighbours, Ms A was admitted to an acute mental health ward at a hospital (part of the trust). She was detained under the Mental Health Act 1983 for treatment for seven weeks. She was diagnosed with acute schizophrenia-like psychotic symptoms. Following discharge, she was cared for by the trust's Early Intervention Team (EIT).
- February 2017 – Ms A was again admitted to the same ward at the hospital and detained there, this time following a violent attack on a family member. During her stay she spent time on a psychiatric intensive care unit in the hospital.
- May 2017 - Ms A was discharged home on a Community Treatment Order (CTO).
- October 2017 – Ms A's CTO was renewed for a further six months.
- May 2018 – Ms A was discharged from her CTO by her consultant psychiatrist.
- December 2018 - Ms A was transferred from the Early Intervention Team to the Community Mental Health Team (CMHT), which continued to be responsible for her care and treatment until March 2020.
- March 2020 – incident took place.

2.3 The main finding and conclusions from the Verita review are set out below.

2.4 Our expert summarised Ms A's case as follows:

"The risks when Ms A's mental health deteriorates are significant.

"Ms A had a history of ambivalence around medication – this further increased the risk, which was particularly significant when she was taking oral medication.

"These issues could best be dealt with by trying to ensure that Ms A agreed to, and accepted, depot medication (i.e., by injection).

"The depot needs to be carefully prescribed, with anti-side-effect medication, for maximum effectiveness."

2.5 The expert believed that these facts should have been clear after the incidents in 2017, if not 2015.

2.6 Our report identified a number of areas where the trust could learn from this case. We believe that this learning may have lessons for other trusts across the country.

2.7 The most important finding was that the trust's understanding of risk concepts was poor. While there were good examples of practical decision-making around risk and medication, the overall risk that Ms A posed was not given sufficient weight. When Ms A's mental health worsened, the risks were significant. The trust's policy and documentation, and the way that it was interpreted by some staff, placed too much emphasis on how a service user presented on any given day, rather than their underlying risk profile. This focus on the '*weather rather than the climate*' was at the heart of the trust's failure to properly understand the unchanging risk that Ms A posed.

2.8 Another important finding was in relation to the documentation of risk. Our expert's summary of Ms A's case is a little more than 50 words, but it gives any reader the essentials of what they need to know. Even a close reading of the trust's eight-page risk assessment form would provide less information than this – and it would take many hours of studying Ms A's extensive clinical records to get the same understanding. We concluded that a way must be found for this sort of summary to be prominently displayed at the top of clinical records. If good examples of this being done in other trusts are not available, NHS England should review how it can be done.

2.9 We recognise that there are a number of constraints operating on the trust and its staff. These include:

- The legal framework in which it operates
- Financial pressures that mean that care co-ordinators and consultant psychiatrists work under high pressure with large workloads

- Practicalities – that options for dealing with service users who do not engage with staff are limited.

2.10 Nevertheless, it is vital that staff ensure that they have the facts of each case and record them properly. There are examples, particularly with regards to events in 2017, where there was a lack of curiosity so that the trust never got to the bottom of what happened.

2.11 Furthermore, there were times when it was evident that the trust had not fully '*bottomed out*' clinical aspects of the case – in particular in relation to Ms A's medication where there was an oscillation between controlling her symptoms and addressing the side-effects that she suffered.

2.12 We welcomed the trust's moves to use zoning and multi-disciplinary meetings more effectively so that staff can provide each other with greater challenge and support. We believe that an open, inquisitive culture would have improved the likelihood that more imaginative steps in handling Ms A's care could have been taken.

2.13 The Verita report made five recommendations, which are discussed in Section 4:

R1 The trust should review its risk policy to ensure that static risks are identified, and realistically assessed, and unnecessary weight is not given to dynamic factors.

R2 When the trust has updated its risk policy, it should ensure that staff have a clear understanding of how to assess risk accurately.

R3 The trust should ensure that a concise summary of the risks of each patient to themselves and others is prominently displayed on the patient record.

R4 If there are not good examples of other trusts displaying concise summaries of risks prominently on patient records, NHS England should examine how it can support trusts to do this.

R5 The trust should continue to review zoning and multi-disciplinary team meetings to ensure that they promote a positive discursive atmosphere where staff challenge and support each other.

3. The response of the trust to the review

3.1 The trust accepted the findings of the Verita review. In their public response they said:

> *"We accept the findings of the external review into the tragic incident.*
>
> *"We note the recommendations highlighted in the report, which will be actioned as a highest priority, and regularly reviewed."*

3.2 The trust has taken a number of actions relevant to our recommendations, including those taken following the incident in March 2020 and those in response to our report. The following is a timeline relating to those actions:

- March 2020 – Incident occurred
- March 2021 - Clinical Risk Policy and staff training package updated
- October 2021 - Clinical Risk Task and Finish Group set up to review current risk assessment tool to develop a summary document
- May 2022 - Verita report
- May 2022 – Clinical Risk Policy reviewed
- July 2022 - Clinical Risk Workshop with representatives across the trust. Reviewed work of task and finish group and agreed on further work programme. Quality Improvement Programme established to implement findings.
- October 2022 – Presentation on the Quality Improvement Programme to trust-wide Quality Improvement Committee
- July - October 2023 - replacement clinical risk assessment tool piloted.

3.3 The trust described the objectives of the task and finish group as to:

"Review the risk assessment tool and design something that captured the risks, formulation and the translation of these into a management plan that was easily accessible in Paris…

"The group agreed purpose of the meeting is not just to produce a new tool but to ensure this works in Paris and that the focus is on formulation and collaborative management of risks and to develop the clinical risk assessment process, policy and training."

3.4 The July 2022 workshop was led by the trust's chief nurse. A presentation was given by a professor of psychiatry at a major university giving advice on risk assessment.

3.5 The trust's next step will be to evaluate the risk assessment tool on the basis of the pilot. An implementation plan will then be developed to roll the tool out across the trust. This will include a further review of the policy, which will then be updated as necessary following the implementation of the new risk tool. This work will be carried out under the Clinical Risk Quality Improvement Programme. The programme is being led by the trust's head of patient safety, associate director of nursing and quality and the quality improvement lead.

3.6 The work is due to be completed in July 2024.

4. Review of recommendations from independent review

4.1 In this section we review each of the recommendations from our review to consider what progress has been made against them.

Report recommendation 1 – the trust should review its risk policy to ensure that static risks are identified, and realistically assessed, and unnecessary weight is not given to dynamic factors

4.2 In our initial review we considered version 1.1 of the trust's Clinical Risk Policy, dated 26 September 2019. The trust subsequently produced an updated version in March 2021 (version 1.2). A further revised version was produced after our initial report. That policy was dated 10 May 2022 (version 1.3).

4.3 The main concern of our independent review centred on the way that risk was described in the trust's policies and other documentation.

4.4 Our understanding of risk, supported by the view of our expert reviewer, is that risks can be sensibly classified into two types – static risks and dynamic risks. Static risks do not decline with the passage of time. In this case, Ms A's tendency to become violent when unmedicated was a risk that did not change over time. Dynamic risks, such as a patient's mood at a time when they are observed, can change. In this case, when Ms A took medication she generally became calmer and her dynamic risks declined.

4.5 In our original report we were concerned that the trust's policy did not make this distinction clear. We found that the trust's policy was confusing. It seemed to give the impression that the passage of time was the key criteria in measuring the seriousness of risk. For example, the policy made a number of references to "*past history*" and "*past risks*". There was also reference in the risk assessment tool to there being a distinction between "*current*" events that happened within the last fortnight, and "*past history*" which happened more than two weeks ago. Our expert told us that there was no evidential basis for this distinction.

4.6 We asked the trust about their response to this recommendation following receipt of our report. They said:

"As the policy already identified that historical and static risk information should be considered when undertaking a structured professional judgement of someone's risks the policy was not updated and the plan was for the policy to be reviewed as part of the work already started to review the clinical risk assessment tool and process."

4.7 The trust told us that they wanted to focus on reviewing the process of risk assessment and the surrounding documentation and training before they changed the risk policy. They acknowledged that this process had taken longer than they originally anticipated.

4.8 The trust's current risk policy describes a '5-step' structured professional judgement approach to risk management. This aims to assist in assessing, formulating, communicating and managing clinical risk. The trust say that the policy is based on the Department of Health's 2007 Best Practice Guidance.

4.9 The trust's policy makes a single reference to static factors. The policy states that the structured professional judgement approach:

"… combines an understanding and consideration of both static factors such as past history and demographic considerations, with dynamic factors, such as mood, mental state and current presentation that are subject to change or fluctuation."

4.10 The policy makes no other reference to static factors. It does not define the term or explain how static factors should be used in formulating risk.

4.11 The policy goes on to say:

"At the formulation stage the aim is to summarise the risk assessment information collected in order to generate an understanding of the risks presented by the Service User and the things that may increase or decrease that risk.

"Information from assessments of strengths, needs and risks should be considered to concisely describe and explain the risk(s) in terms of the:

• History and nature of previous risk(s) (including type, severity and frequency of past/recent risk(s). A summary to explain what might have led to previous risk behaviour is required here.

• Nature of current risks (imminence and likelihood of harmful outcome and recent changes in risks).

• Protective factors and/or personal strengths - These are any characteristics of a person, his/her environment or situation which reduces risk. Examples would include personal coping strategies, motivation for treatment, constructive activity, family, social and professional support.

• Warning signs for the future (early risk signs, factors which will trigger, increase, maintain and/or protect against or prevent risk behaviour).

"The risk formulation should be the reference point to concisely explain and communicate current risks, signs of increasing or decreasing risk and provide the basis for management interventions and plans. The formulation of risks should wherever possible be a collaborative process that is shared with the Service User and any carers."

Comment

A good risk assessment requires the combination of two types of information: dynamic and static factors.

The trust's policy describes a range of dynamic factors. Dynamic factors are likely to be in the forefront of an assessor's mind as they complete an assessment as they will usually have recently engaged with the service user.

However, the immediacy of dynamic factors makes it possible that an assessor will give them too much weight and not value static factors sufficiently. For this reason, it is particularly important that a risk policy clearly sets out the need to have the patient's history in mind when making an assessment, not just the factors that are immediately presented to the assessor.

The trust's policy fails to do this. The policy juxtaposes* "past/previous risks" *with* "current risks". *This represents a complete misunderstanding of risk. Static risks are just as much current risks as things that happened in the past.

Similarly, throughout its documentation the trust refers to "past history". Information about a service user's condition is their current history. Referring to it as 'past history' is an error which leads an assessor to undervalue the importance of things that happened in the past.

Furthermore, it is difficult to understand the logic of amending paperwork and training materials without first having a clear understanding of the terms being used and setting them out in policy.

Recommendation

R1 The trust should urgently review its clinical risk policy to ensure that it accurately describes risk concepts, making clear how static risks interact with the current situation, to ensure that staff give sufficient weight to static risks when making risk assessments.

Report recommendation 2 – when the trust has updated its risk policy, it should ensure that staff have a clear understanding of how to assess risk accurately

4.12 The motivation for this recommendation was to ensure not only that the policy was updated with the process of risk assessment clarified, but that the trust ensured that staff were aware that the policy had changed and knew how to use the new one. Clearly the value of this recommendation is limited if the trust had not updated the policy.

4.13 The trust told us that their risk training was reviewed and updated December 2020. The trust said that the training "*includes information for staff on static and historical risks as well as dynamic risks*". Staff are required to carry out risk training every three years.

4.14 The trust provided us with:

- The slides used for 'Clinical Risk Assessment, Formulation and Management Training'
- Pre-training information provided to attendees
- Post-training information provided to attendees (including information on risk formulation, RAG rating and information on positive risk taking)
- A feedback form.

4.15 The training slides make reference to the service user's history being relevant information for risk management. As noted by the trust, they also refer to static and dynamic risk factors. They say:

> *"A risk factor is a personal or contextual characteristic or circumstance which causes or facilitates risk to occur*
>
> *"Static risk factors are unchangeable e.g. past history, age*
>
> *"Dynamic factors are changeable e.g. mental state, substance use."*

4.16 A subsequent slide refers to RAG rating. This says:

> *"The Red Amber Green rating is based on current risk, the level of intervention required and frequency or review and should inform the management plan".*

Comment

The reference to static and dynamic factors is welcome.

Clearly the slides from training do not tell the whole story of what is said to attendees. However, the notes we have seen do not give any indication that the issue of how static and dynamic factors interact is discussed in the training. The concern arising from our report was that it would be natural if those carrying out assessments had the current presentation of service users in mind and did not give sufficient emphasis to static factors that do not change.

The reference to RAG ratings being based on "current risk" adds to our concern that this recommendation hasn't fully been implemented. Static factors are just as much a part of current risks as dynamic factors are - but there is a danger that this could be missed unless it is spelt out.

To build on the work that has been carried out to develop its training programmes, the trust should add specific reference to the importance of static risk factors in RAG ratings.

Recommendation

R2 The trust should make it explicit in training materials that the formulation of risk must involve consideration of both static and dynamic factors.

Report recommendation 3 - The trust should ensure that a concise summary of the risks of each patient to themselves and others is prominently displayed on the patient record

4.17 A key feature of this case was that, while there were a few essential things that it was important to know about Ms A's treatment, they were difficult to find amongst a very long patient record.

4.18 The trust has carried out work to produce an improved Clinical Risk Assessment Tool to address the issues in this case, as well as similar issues from other serious incident investigations.

4.19 We were provided with two drafts of the tool, one two pages long and the other six pages long. The shorter version (which is included here as Appendix B) focuses on risk formulation, key steps and factors increasing and decreasing risk. The longer version of the form makes a distinction between various domains: harm to self, harm to others, self-neglect, exploitation vulnerability, and safeguarding issues.

4.20 The trust is currently trialling the two versions of the form to see which approach works best.

Comment

It is welcome that the trust is addressing this issue directly.

A short form would obviously be ideal, although designing a form that includes all the relevant information is, of course, difficult. For example, the shorter version of the form does not distinguish between danger to self and danger to others, a distinction which it is important to record clearly.

Although the longer version of the form includes boxes for "past history" and "current situation" it does not provide any guidance on the importance that static events (that may have happened in the past) have for the current position. As we have highlighted, the use of this terminology is likely to lead the person completing the form to downplay the importance of things that happened some time ago.

Report recommendation 4 - If there are not good examples of concise summaries of risks, NHS England should examine how it can support trusts to do this

4.21 We asked NHS England about their response to this issue. They told us:

> *"We spoke with [the trust] regarding this and they advised that they had worked on 'trusts displaying concise summaries of risks prominently on patient records' and did not need us to source examples from other Trusts and they explained the work that they had undertaken, which resolved this issue."*

Comment

We welcome the fact that the trust is making progress in resolving this issue for themselves.

It seems likely that this issue is relevant to other trusts. If so, we hope that NHS England will liaise with other trusts to share best practice.

Report recommendation 5 - The trust should continue to review zoning and multi-disciplinary team meetings to ensure that they promote a positive discursive atmosphere where staff challenge and support each other

4.22 The trust uses a process of daily multi-disciplinary meetings involving the whole team to review the risk profile of patients and 'zoning' to identify which risk category they fall into. The trust's internal investigation made a recommendation that this process be reviewed. The trust subsequently changed its standard operating procedure to encourage attendance at meetings and to encourage attendees to stay for the whole meeting. These changes were in the process of being implemented when we wrote our report.

4.23 In our report, we welcomed the changes that the trust was making in this area. We said that we believed that there were occasions in this case where more challenge or diversity of views, such as in multi-disciplinary teams (MDTs) would have led to better decision-making. Our recommendation was aimed at encouraging the trust to continue to make these changes and ensure that they were embedded across the trust.

4.24 The trust has said that the Covid pandemic had an impact on the operation of the zoning process. As a result, the trust held a trust-wide learning event in September 2021 to share good practice. Community mental health teams, including the one involved in this case, shared their experience in implementing the process. The trust told us that this process is embedded in some of the teams, but that it is still not fully implemented across the trust. Work is underway to ensure that zoning standards and guidance is reflected across the trust. An audit of multi-disciplinary meetings will be completed shortly to ensure that best practice is spread across the organisation.

Comment

The trust has already adopted an improved approach to multi-disciplinary teams and zoning in the team where this incident occurred. Progress in rolling this out across the trust has been slow, hampered by Covid. The trust should continue to promote this initiative so that best practice is shared across the organisation.

5. Conclusions and recommendations

5.1 The trust accepted the recommendations of our original report. It is clear that progress with implementing the recommendations has been slower than anyone, including the trust, would have wanted. Covid has been a factor in this, but the trust has also faced several other issues which it has had to focus on.

5.2 The trust has made some progress with regards to improving training and putting together materials to help staff make better risk assessments. This is to be welcomed.

5.3 The trust could build on this by ensuring that its senior team has an agreed and clear understanding of risk and how the terms it uses are defined. This will enable them to take the next step in further developing its approach to risk management.

Recommendations

R1 The trust should urgently review its clinical risk policy to ensure that it accurately describes risk concepts making clear how static risks interact with the current situation to ensure that staff give sufficient weight to static risks when making risk assessments.

R2 The trust should make it explicit in training materials that the formulation of risk must involve consideration of both static and dynamic factors.

Appendix A

Documentary evidence

In carrying out this review we reviewed the following documents:

- Trust Clinical Risk Policy (versions 1.1 and 1.3)
- Clinical risk training documentation, including pre and post training information, training slides, feedback form
- Draft summary risk assessment tools for consultation
- Papers from clinical risk task and finish group, March/April/May 2022
- Papers for clinical risk assessment workshop, July 2022
- Presentation on the Quality Improvement Programme to trust-wide Quality Improvement Committee.

Appendix B

Trust clinical risk assessment tool

Full Name:
NHS Number:
RISK FORMULATION including Service user and Carer View
Summary Formulation – ***consider the nature and degree of risk , who is at risk , how likely is it , relationship between risk and mental disorder , current social circumstances or contextual factors***
Key Next steps and Safety Plan (*Please provided details to support your plan)*

Summary:
History: *Include incident/events, what, where, when (dates please), and who was involved, cause/trigger, consequences, and risks. Consider family history of suicides*

Current Situation: ***include service user and carer/family/friends' views***

Level of thoughts/plan/intent/behaviour/means to harm self. Responding to command hallucinations. Level of distress, helplessness / hopelessness.

Demographic and situational risk issues e.g., age, employment, relationship status, major life events or anniversaries

Support network and coping strategies

Factors Increasing Risk:

Factors Decreasing Risk:

Was the service user involved in the risk assessment *(Please provide details)*	**YES/ NO**
Does the service user agree with the findings of this risk assessment *(Please provide details)*	**YES/ NO/ UNABLE TO AGREE**
Service User / Carer / representative Signature:	**Date:**

Practitioner Name:	**Signature:**
Designation:	**Date:**