Tees, Esk and Wear Valleys
NHS Foundation Trust

**RESPONSE TO: 'An independent review of the investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust into the care and treatment of Mr H' (September 2022)**

The above independent desk top review examined an internal homicide investigation which was completed by Tees Esk, and Wear Valley NHS Foundation Trust, in 2018, into the care and treatment of Mr H.

The purpose of the independent review was to determine whether the Trust's review robustly considered and explored key lines of enquiry and if not, to identify any areas requiring further examination.

The external review was completed in September 2022 and made several recommendations which fell into two categories:

- Recommendations **1- 4** related to the standard of the internal investigation and sign off process.
- Recommendations **5-12** related to issues with the care provided to Mr 'H'

The Trust is committed to adopting a systems-based approach to learning to improve the delivery of care provided to people who use our services, we therefore fully accept the recommendations made by the external review.

The Trust's response, detailed below, identifies actions that will be taken in response to the recommendations made by the external review as well as assurance and/or improvement work that has already been carried out in the areas identified.

**Recommendations 1- 4 standard of the internal investigation and surrounding sign off (see Appendix)**

**IMPROVEMENT**

The Trust has had a continued focus on improving the quality of incident reporting, investigation, and identification of key learning since 2019. A programme of work was developed to deliver transformational change that takes into account valuable feedback received from patients, families and partners identified through a range of engagement activities and events.

A Strategic Project Manager was appointed, and additional support has been provided by NHSE/I's System Improvement Team. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

Some examples of improvements made to the process include ensuring that patients, relatives, and carers are involved in investigations as equal partners, improving the triage of

incidents, and introducing Rapid Patient Safety Reviews. To improve the quality of incident investigations, specialist subject matter advisors are involved in daily patient safety huddles and incident investigations. Further work is currently focusing upon the Assurance Panels where the Serious Incident Investigation reports and action plans are formally presented and considered by the panel for formal sign off. This improvement workstream forms part of the Trust's key quality priorities within its Quality Journey, the Trusts quality strategy with formal governance routes in place.

**ACTION**
There will be constant monitoring over the next 12 months as PSIRF is implemented to evaluate the effectiveness of the Trust's investigation processes against best practice and national guidance.

**Recommendations 5 - 12 relating to care issues**

There were several care issues identified in the external high-level care review

**Recommendation 5**
**It is important that the specific learning from this case is maximised. The Trust should either ensure a full care and treatment review is undertaken for Mr H examining each of the gaps identified in this review or commit to ensuring the extent of each of the following gaps are clearly quantified for patients across the Trust's services and actions to address them are referenced within the Trust's improvement programme.**

**IMPROVEMENT WORK**
Community Transformation work will facilitate collaborative pathways across the system it operates within, creating a core mental health service which is aligned with primary care networks and voluntary sector organisations. The transformation work will ensure services are accessible to the community it serves and inclusive of population need. It will allow individuals seeking advice and support - the right care, at the right time in the right place and in doing so ensure timely access to care. This holistic approach across the system will address several of the gaps identified in Mr H's care including evidence of multi-agency working and issues with housing.

We aspire to work with people with co-existing substance misuse issues, and not exclude anyone from accessing mental health services based on concurrent substance misuse. As part of our clinical journey, we will ensure that our Staff are confident and competent to support people who misuse substances including those with addictions and have access to expert advice when needed. Services will respond effectively and flexibly to presenting needs. We will work together with partners in primary care, local authorities, and the voluntary sector to improve access to services which can minimise harm, improve health and enhance recovery. We will be guided by those with lived experience.

Since this incident, the Trust has introduced a comprehensive quality assurance programme that focuses on the quality of care being delivered across Trust services, focussing on care plans, safety planning (risk assessment and management) and co-production. Significant work has also been undertaken to review historic Serious Incidents to maximise opportunities for learning by focussing on key themes arising from these which are monitored through ongoing improvement work.

**ACTION:** The Trust has established a dual diagnosis strategy task and finish group to progress the drug and alcohol aspect of our clinical journey. As part of this work, the Trust will define what it can offer those with dual diagnosis needs, establish what is already in place to deliver this and where we have gaps/areas for development. We will then be able to develop high-level actions needed to deliver the care and support required.

Other gaps identified in recommendation 5 are addressed by other recommendations detailed below.

**Recommendation 6 – within 12 months, the Trust should develop a system to ensure multiple services are monitored effectively to identify potential patient risk and ensure care plans are adequately reviewed.**

**ACTION:** The Trust will review current systems for repeat referrals, screenings and assessments across the Trust focusing upon processes for monitoring, oversight, and escalation. Based on the outcome of this review, we will identify where there are areas for improvement and initiate improvement work to address this.

**Recommendation 7 – within 6 months, the Trust should seek assurance on how it supports individuals with complex presentations, developing and providing guidance for staff on key referral and care planning pathways. This should include consideration of any additional assessments, any referral to specialist services and specialists (forensic, dual diagnosis) and consideration of increased psychiatric review for individuals with complex presentations. As part of the guidance for complex cases the Trust guidance should develop a referral pathway for forensic assessments.**

**ACTION:** The Trust will undertake a review of current referral and care planning pathways for patients with complex presentations. Based on the outcome of this review we will identify where there are areas for improvement and initiate improvement work to address any gaps.

**Recommendation 8 – within 6 months, the Trust should provide assurance that staff can access additional clinical advice and support when working with individuals with complex presentations. This should be provided as part of the post-publication assurance review.**

**IMPROVEMENT WORK**

There are numerous ways in which staff can obtain additional clinical advice when working with individuals with complex presentations. Since this incident the Trust has significantly invested in Community Modern Matrons and Practice Development Practitioners whose roles are to provide additional clinical leadership and support to clinical staff. There are also dedicated Dual Diagnosis Lead posts in some front-line services, for example crisis teams. Clinical areas have access to multi-disciplinary team (MDT) huddles, these are meetings where people with complex presentations and needs can be discussed. Multi-agency strategy meetings and/or complex case meetings are also available should staff feel more in-depth discussions are required between partner agencies.

Where possible the Trust works collaboratively with emergency services, the voluntary sector and local authorities to help identify individuals who frequently present in distress to multiple public services. A range of organisations attend 'Familiar Faces' meetings to discuss and share information and agree a collaborative approach to supporting and managing these individuals. This collaborative working agreement is documented in a Familiar Faces multi-agency plan which is inclusive and consistent with the core objectives and responsibilities of each organisation.

**ACTION:** The Trust will undertake a Trust-wide review of ways in which staff can access additional clinical advice when working with individuals with complex presentations. Based on the outcome of this review we will identify where we can share good practice as well as areas for further development.

**Recommendation 9 – within six months the Trust should provide assurance that current hospital discharges are completed in line with agreed policy.**

**ACTION:** The Trust will undertake a clinical audit of practice against the standards set out in the Admission, Transfer and Discharge policy. We will also triangulate any themes arising from incident data with clinical audit data to identify any areas for improvement.

**Recommendation 10 – within six months, the Trust should provide assurance that adult safeguarding practice is in line with agreed policy.**

**IMPROVEMENT:** A Safeguarding policy has been developed which supports the existing procedure already in place. The Safeguarding policy, which was ratified in June 2022, clearly outlines the roles, responsibilities and accountability of staff at all levels of the organisation as well as governance arrangements. The provision of staff training continues to develop and improve staff knowledge and skills, supporting policy implementation.

**ACTION:** An Audit of compliance with safeguarding practice as defined in the Trusts policy is scheduled to take place by the end of December 2022.

**Recommendation 11 – within six months the Trust should provide guidance regarding recording and oversight for individuals subject to public protection measures such as MARAC and MAPPA.**

**ACTION:** The Trust's Safeguarding Adult policy was reviewed and published in June 2022 and includes guidance on recording and supervision for individuals subject to MAPPA. Within 6 months the Trust will undertake a review of Trust guidance for recording and oversight for individuals subject to MARAC. Further actions will be determined by findings to ensure that any actions are disseminated Trust wide by the most appropriate means.

**Recommendation 12 – within 6 months, the Trust should provide assurance that carers are being offered the opportunity to receive carer assessments as per Trust policy.**

**ACTION:** Assurance that carers are being offered the opportunity to receive carer assessments will be obtained by including this question in the Trust's Quality Assurance Programme for both in-patients and community services. This will identify any areas for improvement which will feed into the existing Triangle of Care workstream.

## APPENDIX 1

**Recommendation 1**

The Trust should implement an annual audit programme which evaluates the effectiveness of the Trust's investigation processes against best practice and national guidance.
This should include:
• a review of the application of RCA methodology; ensure review of medication is a standard part of any investigation
• the panel review process; family engagement and involvement; and the quality assurance of the final report.

**Recommendation 2**

The Trust should ensure that:
• the quality assurance process for signing off serious incidents/homicides is strengthened and the reasons why this was not adequate in this case are understood
• independence from services in investigations is given priority
• the Integrated Care Board (ICB) is given sufficient opportunity to sign off and challenge the findings.

**Recommendation 3**

The Trust should ensure there is appropriate application of Duty of Candour in this case and secure assurance that it is applied correctly in all cases of homicide.

**Recommendation 4**

Given the transition to Integrated Care Systems (ICS); NHS England should ensure the North East and North Cumbria ICS and ICB learns from this case to secure robust future sign off processes as part of the new Patient Safety Incident Response Framework (PSIRF).

**Recommendation 5 – within 6 months**

It is important that the specific learning from this case is maximised. The Trust should either ensure a full care and treatment review is undertaken for Mr H examining each of the gaps identified in this review or commit to ensuring the extent of each of the following gaps are clearly quantified for patients across the Trust's services and actions to address them are referenced within the Trust's improvement programme.

These include:

• the impact of substance and alcohol misuse, on Mr H's mental health, diagnosis, or associated behaviour; whether substance misuse impacted on Mr H's engagement with services, and whether his associated behaviours impacted on how services responded to him.
• the relationship with housing providers to establish if other housing options were available, whether unstable housing impacted Mr H's engagement and his access to services and treatment.
• all factors that may have impacted upon engagement, particularly focusing on services' responses to see whether they met expected practice. We also recommend that the VCB6 Guidance is considered to establish what, if any, impact this may have had on his care journey.
• the diagnostic management and clinical decision-making to establish if practice was in line with expected care and treatment. It would also identify if there were gaps in services or whether the existing models of service, if applied more robustly, would have been sufficient.
• the use and appropriateness of medication and Mr H's compliance with this.
• Mr H's forensic history and engagement with the criminal justice system.
• consideration of his discharge in 2017 to determine whether this was in line with expected practice.

• adult safeguarding practice to determine whether this was in line with expected practice.
• multi-agency working to determine whether this was in line with expected practice.
• care planning to determine whether this was in line with expected practice.
• risk management and crisis planning to determine whether this was in line with expected practice.
• exploring any interlinkages between Mr H and Mr B to understand if there is any learning.