Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Independent External Reviews of Homicides:

An evaluation of reviews undertaken by Healthcare Inspectorate Wales since 2007

March 2016

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1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of health care in Wales.

Our Purpose
To provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

Outcomes

Through our work we aim to:

Provide assurance:

Provide independent assurance on the safety, quality and availability of healthcare by effective regulation and reporting openly and clearly on our inspections and investigations.

Promote improvement:

Encourage and support improvements in care through reporting and sharing good practice and areas where action is required.

Strengthen the voice of patients:

Place patient experience at the heart of our inspection and investigation processes.

Influence policy and standards:

Use our experience of service delivery to influence policy, standards and practice.

This report pulls together the key themes from the 13 independent external reviews of homicides committed by individuals known to mental health services in Wales published by HIW since 2007.

2. Background

Prior to 2007, independent external reviews into homicides committed by individuals known to mental health services were commissioned by Local Health Boards. The investigations themselves were conducted by review teams brought together from third party health bodies or through commissions with the private/independent sector.

Since 1 January 2007, HIW has been commissioned by Welsh Government to conduct these independent external reviews. To date, HIW has published a total of 13 reviews. Where individual reviews included significant elements relating to social services, arrangements were made to include Inspectors from Care and Social Services Inspectorate Wales (CSSIW) in the review team.

The decision on which reviews HIW undertakes is made by Welsh Government's Mental Health, NHS Governance and Corporate Services Division in consultation with the Quality and Safety Team and health professionals within Welsh Government. The decision is made on a case by case basis dependent upon many factors, such as findings from the Health Board's own internal investigation, the proportion of time the perpetrator spent in contact with mental health services, and consideration of judicial proceedings.

The aims of HIW's reviews are to:

- Consider the care provided to the individual as far back as his/her first contact with mental health services to provide an understanding and background to the fatal incident
- Review the decisions made in relation to the care of the individual
- Identify any change or changes in the individual's behaviour and presentation, and evaluate the adequacy of any related risk assessments and actions taken leading up to the incident
- Produce a report detailing relevant findings and setting out recommendations for improvement, working with key stakeholders to develop an action plan(s) to ensure lessons are learnt from this case
- Consider the effectiveness of multi-agency interfaces and any potential barriers to effective partnership working in the provision of care.

Although each individual report concentrates primarily on those services which engaged with the individual in question, HIW believes that these reports are pertinent to many services in Wales, and that all health boards should examine the findings and recommendations in these reports.

Whilst the circumstances and details of each case that HIW has examined since 2007 has been very different, the emergence of common themes and findings has become apparent. HIW believes that it is timely to draw these themes together in a single report and to assess the impact that these reviews have had on services that are being provided to mental health service users.

The purpose of the evaluation was to:

- Undertake a detailed analysis of the findings and recommendations identified in all homicide reviews
- Identify whether there were common theme/s to recommendations
- Assess the impact the reports, and the recommendations issued since 2007, have had on services that are being provided to mental health service users
- Identify the benchmark for improvement and examples of best practice on a national basis, and consider how best practice may be effectively shared
- Produce recommendations for referral to the appropriate forum, new or existing
- Identify areas of improvement and learning to be taken forward by stakeholders.

As part of this work HIW has sought to engage with services and stakeholders to identify any barriers to improving services.

Furthermore this exercise also identifies what learning HIW can take forward in relation to its own processes.

The methodology for undertaking this evaluation can be found at **Annex A**.

3. Summary

Thirteen reports have been published by HIW since our reviews began in 2007. The broad themes contained in these reports were:

- Care Planning, Assessment and Engagement with Families/Carers
- Risk Management
- Diagnosis
- Discharge and Aftercare Planning
- Integrated and co-ordinated services
- Communication and Information Sharing.

Our discussions with stakeholders found that they all continue to recognise these issues within their own organisations.

It is clear that there have been inconsistencies regarding the implementation of care and treatment planning in Wales, and we have also seen an inconsistency of approach in relation to patient risk assessment and risk management across several (eleven in total) of our reviews. HIW's reports have spanned the transition from Care Programme Approach (CPA)[1] to the Mental Health Measure[2] (CPA 2005-2012, the Measure implemented from 2012 onwards) and these findings apply to both periods of time. In many cases we found that the risk assessment processes were undermined by the lack of relevant or pertinent information (in part due to lack of effective information sharing between agencies/organisations). However, we also found inconsistency in terms of the methods used to undertake patient risk assessments.

The lack of effective care planning and risk assessment has also had a detrimental impact on case formulation[3] and diagnosis in three of the cases that we reviewed.

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[1] CPA was introduced in Wales in 2003, becoming a formal requirement in January 2005. See: http://www.nhs.uk/conditions/social-care-and-support-guide/pages/care-programme-approach.aspx

[2] The Mental Health (Wales) Measure 2010 December 2010 but came into force in June 2012. See: http://gov.wales/topics/health/nhswales/healthservice/mental-health-services/measure/?lang=en

[3] A theoretically based explanation or conceptualisation of the information obtained from a clinical assessment. In clinical practice, formulations are used to communicate a hypothesis and provide framework for developing the most suitable treatment approach.

Again the key issue was a lack of effective communication or sharing of information, undermining the ability of professionals to make a fully informed diagnosis. In these cases a diagnosis, predicated on incorrect or inaccurate information or assessments (Mr J and Mr M for example), has had a negative impact on the care subsequently provided to those individuals.

In four of the reviews we found that provision of services for individuals who are diagnosed with a personality disorder was inadequate. We found a lack of dedicated patient-focused services and inadequate training for staff in the assessment and treatment of personality disorder, thus preventing individuals from receiving the most appropriate care and treatment for their diagnosis.

Whilst we have noted both during our analysis and subsequent discussions with stakeholders that some specialist personality disorder services do exist, we have learnt that patients who require more specialist and intensive therapy have to be referred to England. Our work suggests that personality disorder services more broadly across Wales are lacking, with a need to address this gap in provision.

Six of our reviews highlighted a lack of effective discharge planning, or aftercare arrangements being in place for many of the cases we reviewed. We found the standard of documentation poor in several cases and that there has been limited information shared with relevant parties in regards to relapse indicators. This is particularly significant as most of the individuals examined during the course of our reviews had a history of relapse, history of repeat admissions and reluctance to engage with services. In these instances, strong discharge arrangements are imperative to ensuring continuity of care.

Clear themes have also emerged in eight of the reviews in relation to effective leadership and management of Community Mental Health Teams[4] (CMHT), with issues relating to how these multi-disciplinary teams[5] work together and how individuals are managed and supervised. During several of our reviews we found a need to strengthen the integration of both health and social care staff within CMHTs and the need for organisations to ensure that the CMHTs each have clear overall clinical and managerial leadership.

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[4] See: https://www.rethink.org/diagnosis-treatment/treatment-and-support/cmhts

[5] Community Mental Health teams consists of a multi-disciplinary team of professionals who work with adults with medium to long term psychological and psychiatric problems of significant complexity and seriousness. Team members may include a psychiatrist, social worker, community psychiatric nurse, psychologist, psychotherapist, and support staff.

One theme that remained constant across our 13 reviews is communication and information sharing. Communication is a broad theme and in many senses all of the themes could be encapsulated by this heading. However, our analysis suggests that key issues such as appropriate information sharing between (and within) organisations, and between professionals have had a significant impact on the quality of care and treatment provided to patients.

We have considered the effectiveness of information sharing within all of our reviews. Significantly, our reviews have pointed towards a lack of effective processes or even a mutual understanding of the importance of the timely sharing of information. In many, if not all of the cases we examined, this has had a detrimental effect on the care and treatment provided to individuals. Too often we have seen the consequences of a lack of accurate and relevant information being fed into care planning or risk assessment processes.

Feedback from key stakeholders on the impact of our reports has been varied. There is evidence to suggest that some organisations which were not the direct subject of a review, had established their own internal process to look at the recommendations from each report. However, some organisations had no formal process or mechanism in place to ensure wider learning from our reports. This is disappointing, as a key potential benefit of undertaking these reviews relates to wider learning and HIW places emphasis on these reviews being noted and acted on by all health boards.

Some of the barriers to the implementation of the recommendations arise when action is required across multiple organisations or agencies, including non-health bodies. In addition, stakeholders that we spoke to felt that one of the problems with regards to implementation of recommendations was where these related to Wales-wide issues. One suggestion we received was that these recommendations ought to be driven and directed by Welsh Government. One possible forum suggested by Welsh Government for this could be the Untoward Incidents National Steering Group that HIW and Public Health Wales (PHW) works in partnership on. The group was established in 2012 to lead and coordinate an improvement programme on untoward incidents in mental health and related services to people of all ages, including homicides and other serious untoward incidents.

Similarly, it was proposed that where we have issued a series of recommendations across single or multiple homicide reviews that are applicable on an all-Wales basis that HIW could focus on these specific themes in more detail as part of its overall programme of work.

We were told that HIW should consider holding an annual ‘event’ to feed-back on issues emerging from our reviews and all-Wales applicable recommendations. Again

the Untoward Incidents National Steering Group may be the most effective forum to do this through.

All of the stakeholders who had been subject to review said that our reviews were invaluable and should continue. There is an appreciation of the level of detail contained within our reports and it was felt that this was important in providing context and justification for the subsequent findings and recommendations.

There was also helpful feedback in regards to our own processes in undertaking the reviews. This includes improving how we circulate our reports, the inclusion of an executive summary (now addressed), and how we share and discuss the issues that emerged during the review process itself in advance of the report being published.

Finally, Welsh Government also indicated to us that our reports are valued and have a positive impact, providing assurance to the reader that our reviews are objective. Welsh Government also praised the level of detail contained within our reports, seeing this as a positive feature that enabled the findings to be presented in an open and transparent way. Welsh Government sees these reports as playing an important role in ensuring these tragic incidents are looked at, and most importantly, learnt from.

4. Key Themes

As part of our analysis, we completed a detailed assessment of the comparative findings and recommendations identified in all completed HIW homicide reviews. The key themes that emerged from our analysis are as follows:

- Care Planning, Assessment and Engagement with Family
- Risk Management
- Diagnosis
- Discharge and Aftercare Planning
- Integrated and co-ordinated services
- Communication and Information Sharing.

Care Planning, Assessment and Engagement with Family

The Care Programme Approach (CPA) was introduced in Wales in 2003, becoming a formal requirement in January 2005. CPA provided a comprehensive framework that assisted organisations and services to effectively manage and support individuals with high levels of need or risk. It provided them with personalised and multidisciplinary care plans and enforced the need to ensure that the CPA form was shared across all appropriate agencies and teams, thus enabling the correct and updated information to be available to all relevant organisations.

CPA was replaced by Part 2 of the Mental Health (Wales) Measure 2010[6] (referred here in as the "Measure"), which came into force in June 2012. Part 2 of the Measure sets out new arrangements for the coordination of and care planning for secondary mental health service users.

Our reviews have seen the transition period from CPA to the Measure and during both periods we found that there has been an immaturity in the application of care

[6] The Mental Health (Wales) Measure 2010 is a law passed by the National Assembly for Wales and, as such, has the same legal status in Wales as other Mental Health Acts. However, whilst the 1983 and 2007 Mental Health Acts are largely about compulsory powers, and admission to or discharge from hospital, the 2010 Measure is all about the support that should be available for people with mental health problems in Wales wherever they may be living.

planning[7] and assessment in Wales. This included inadequate attention to the assessment, identification and management of patient risk.

We have found particular issues relating to engagement with individual's families and/or carers in order to gain a complete assessment, both in the context of devising care plans and also the formulation and assessment of risk. In five reviews (Mr B, Mr E, Mr F, Mr G and Mr M) there was limited acknowledgment in the value of drawing information from an individual's family to build a complete picture of the individual's history and patterns of behaviour, and of involving the family appropriately in the monitoring and management of the individual's care and treatment. This was primarily a result of hesitancy in relation to breaching of confidentiality with the individual concerned. Retention of confidentiality of the individual has sometimes inappropriately been given higher importance than gaining further insight from carers or families (the Mr F case was a key example of this). As a consequence this impacted upon the comprehensiveness of the care that could be offered to the individual.

Where care and treatment planning had been carried out, issues remained in relation to the regularity of updating the assessments, the sharing of information with partner agencies (especially in complex cases), and there was little evidence to show that these processes were being routinely audited to monitor compliance. Guaranteeing that such issues are addressed and actioned helps ensure that all elements of an individual's care plans are completed appropriately.

> *During discussions as part of this evaluation exercise* ***Cardiff and Vale University Health Board*** *(CVUHB) told us that they have implemented a system whereby audits of care and treatment plans are undertaken on a quarterly basis. Discussions around care and treatment plans would also form part of the supervision sessions with the Integrated Managers of the*

[7] **Care and Treatment Planning is detailed in Part 2 of the Mental Health Measure**. Local Health Boards and Local Authorities have a joint duty to implement Part 2, and people who receive secondary mental health services have two important new rights:

- the right to have a Care Coordinator appointed to work with them to coordinate their care and treatment, and
- the right to an individual and comprehensive Care and Treatment Plan to assist their recovery.

Community Mental Health Teams/ Ward Manager or deputy. This is a positive step, and is something that should be seen as routine practice across all health boards in Wales.

We found there were also issues regarding the ability of Community Mental Health Teams (CMHTs) to effectively manage patients due to the absence of carefully designed and managed care and treatment plans. Care plans, which need to be jointly formulated between services, should have clear decision pathways thoroughly documented. This aids the provision of seamless services irrespective of the individual's point of entry to these services.

In two reviews (Mr C and Mr E) we found that there was a need for the provision of staff training aimed at developing the skills required to devise care plans. Furthermore, there was a need for training that focuses on how to capture an individual's past history and the triangulation of this information with professionals and the individual's family. The provision of staff training in this area would aid the holistic approach[8] needed to complete robust care plans for individuals, ensuring that the pertinent information is included and that information is obtained from the relevant organisations.

In two reviews (Mr G and Mr L) we found weaknesses in relation to care coordination[9], with a lack of effective or assertive oversight of the individual's care and treatment. This fragmented the continuity of care being provided and led too often to professionals providing care and treatment in isolation of the 'bigger picture'.

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[8] An Holistic approach is an integrated approach to health care that treats the "whole" person, not simply symptoms and disease

[9] Appointment of care coordinator was requirement of CPA and remains a requirement of the Measure. This role can assist in building better relationships between the individual and the services available to them. This allows for oversight of an individual's care and treatment, engagement with services, compliance with medication and provision of important information to mental health professionals with regards to an individual's mental health. A care coordinator will also be able to build a relationship with friends and family. This will aid closer supervision for earlier identification of deterioration in condition, which will in turn allow the provision of appropriate care or access to relevant services. See Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010: http://www.assembly.wales/Laid%20Documents/GEN-LD8880%20-%20Code%20of%20Practice%20to%20Parts%202%20and%203%20of%20the%20Mental%20Health%20(Wales)%20Measure%202010-23042012-232786/gen-ld8880-e-English.pdf

Risk Management

Risk management is a core aspect of a mental health assessment and to support this, a structured and consistent approach should be taken by service providers.

Our analysis has found that that in eleven reviews (Mrs A, Mr B, Mr C, Mr D, Mr E, Mr F, Mr H, Mr J, Mr K, Mr L and Mr M) the methods used for identifying and assessing risk across agencies or organisations was inconsistent and needed to be reviewed to ensure that risk was measured and understood using the same parameters and language. Furthermore, not all risks identified had a corresponding care management and treatment plan, and we also found that risk management was not always fully integrated and thoroughly embedded within the care planning process. Ensuring consistency in managing risk allows all parties involved in a patients' care pathway to collaboratively contribute towards a robust and comprehensive care plan.

In six reviews (Mrs A, Mr B, Mr C, Mr E and Mr M) staff were not always fully trained in the methods for the assessment of risk, and did not always understand the need for more detailed and specific risk management plans. In many cases we found that staff were unclear on how to utilise or refer to the use of specialist tools in making assessments in cases that displayed severe and complex need. An example of this isindividuals whose diagnosis may be complicated by substance misuse.

In four reviews (Mr F, Mr J, Mr L and Mr M) it was clear that whilst risk assessments had been conducted, they were not always systematic or evidence based, potentially hampering an individual's care pathway. We have also identified the need for regular auditing to check for compliance with arrangements for risk management.

Some of our reviews (Mr B, Mr C and Mr J) identified a need for improved inter-agency risk management in terms of ensuring the appropriate representation at meetings to discuss patient care and treatment. For example, at meetings such as Multi Agency Public Protection Arrangements (MAPPA)[10] and Multi Disciplinary Team (MDT) meetings held by CMHTs. In these cases, ensuring the correct representation at such meetings would have assisted in terms of allowing appropriate and relevant information to be shared in greater detail. This would have enabled more informed decisions to be taken and for the completion of more thorough assessments.

[10] See: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

Overall, our reviews have highlighted a need to ensure that robust risk assessments are in place for individuals, as well as ensuring that there is a procedure in place for joint working (including the sharing of information) with external partners when assessing a person's risk.

During our evaluation exercise we have heard examples of organisations having sought to improve the way in which they manage risk in relation to mental health patients:

> ***Cwm Taf University Health Board*** *(CTUHB) has implemented a 'Walk Out Pathway' within their Accident and Emergency (A&E) departments. This pathway states that if an individual leaves A&E without having an assessment (where staff believe they may have a mental health issue), then staff have a specific pathway to follow in relation to any action to take. A&E departments also have 'Frequent Flyer' meetings, where those patients who attend A&E often are discussed if thought to have any mental health issues. These meetings are multi-disciplinary thus ensuring all information from various disciplines is fully considered in terms of forming an evaluation.*
>
> *Another example of how CTUHB has addressed the issues of patient risk is through the employment of a Criminal Justice Liaison Nurse based in the Merthyr Police station. The Criminal Justice Liaison Nurse is responsible for carrying out mental health assessments, providing support and advice, and signposting to other organisations that may be able to offer better support for individuals who are deemed to be in mental health crisis. This post covers the whole of CTUHB.*
>
> ***Cardiff and Vale University Health Board*** *(CVUHB) operates a system, in conjunction with the Welsh Ambulance Service NHS Trust (WAST), whereby if an individual is identified as suffering from a significant mental health issue as opposed to a physical healthcare issue, they are taken straight to Whitchurch hospital for assessment rather than an A&E department. CVUHB also has a dedicated team that deals with individuals who have been identified as having significant forensic history and mental health needs. This is a separate team that deals with high risk individuals only. All other individuals who fall out of this criteria, but still need assessment, will be referred to the CMHTs.*
>
> ***Hywel Dda University Health Board*** *(HDUHB) has a new pilot initiative set up in partnership with Dyfed Powys Police called the street triage mental health service. The system involves police staff, who have been trained in mental health, working in the control room alongside a mental health*

practitioner who works closely with them. In establishing this system an information sharing protocol has been implemented.

As calls are received by the control room, trained staff are able to assess whether the individual in question could potentially be a mental health service user. Where individuals with potential mental health symptoms are identified the calls are tagged as such. Consequently staff are then able to check whether the individual has a history of mental health, including whether the person is currently an inpatient at a mental health hospital within the area.

This approach has allowed for an informed response to emergency calls received by the police, with the aim to reduce the number of individuals being arrested by police under a section 136[11]. Previously this could have resulted in patients spending numerous hours in police custody suites and feeling criminalised.

Consequently both HDUHB and Dyfed Powys Police have received positive feedback from patients and patient relatives. HDUHB subsequently won an NHS award for partnership working as a direct result of this pilot.

***Abertawe Bro Morgannwg University Health Board** (ABMUHB) has set up a risk panel incorporating both community and inpatient psychiatry. This is led by a forensic psychiatrist and meets monthly to review the risk management planning for mental health service users thought to pose a significant risk of violence.*

Diagnosis

The lack of effective care planning and risk assessments has also had a detrimental impact on case formulation and diagnosis in three of the cases that we reviewed (Mr J, Mr K and Mr M). The key issue has again been a lack of effective communication or sharing of information, undermining the ability of professionals to make a fully informed diagnosis. In many cases a diagnosis, predicated on incorrect or inaccurate information or assessments, has had a negative impact on the care subsequently provided to those individuals.

[11] The police can use Section 136 of the Mental Health Act to take an individual to a place of safety when they are in a public place. They can do this if they think they have a mental illness and are in need of care. Section 136 gives the police the authority to take a person from a public place to a "Place of Safety", either for their own protection or for the protection of others, so that their immediate needs can be properly assessed. See: http://www.legislation.gov.uk/ukpga/1983/20/section/36

Personality Disorder

Four of our reviews (Mrs A, Mr B, Mr C and Mr J) highlighted the lack of adequate provision for dealing with individuals diagnosed with a personality disorder[12]. Historically, personality disorder has sometimes been viewed as a diagnosis of exclusion and used as a label for 'the patients psychiatrists dislike'[13]. Our reviews have suggested that in cases where a diagnosis of personality disorder had been made or suggested, it appears that this diagnosis has had a detrimental impact on the care and treatment subsequently provided to those individuals.

We have found a lack of dedicated patient-focused services and inadequate training for staff in the assessment and treatment of personality disorder, thus preventing individuals from receiving the most appropriate care and treatment for their diagnosis. Whilst we have noted both during our analysis and subsequent discussions with stakeholders, that specialist personality disorder services are present in some health boards, we have also learnt that patients who require more specialist and intensive residential therapy have to be referred to England on a case by case basis. Our work suggests that personality disorder services more broadly across Wales are lacking, with a need to address this gap in provision.

Health boards need to ensure that there is adequate provision for the care and treatment of those suffering from a personality disorder. Those health boards which do not have dedicated personality disorder services should ensure that arrangements are in place to access these services where they do exist.

Examples of how some health boards are provisioning for individuals with personality disorder are detailed below:

> ***Aneurin Bevan University Health Board*** *(ABUHB) has a dedicated personality disorder unit which has input from psychological expertise and includes a six bedded rehabilitation ward. Before ABUHB accepts individuals onto this ward, each area has to provide care plans so that assurance can be obtained that staff will be able to meet the requirements of the individual. ABUHB is currently the only health board that offers an all female personality disorder ward. The health board also shared with us that it has plans to deliver training to a broader group of people to help staff increase their understanding and knowledge.*

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[12] See: http://www.nhs.uk/Conditions/personality-disorder/Pages/Definition.aspx

[13] See: http://pb.rcpsych.org/content/27/11/401

Cardiff and Vale University Health Board *(CVUHB)* has a personality disorder/ complex trauma team that has been put in place to provide specialist advice to the CMHTs and in-patient services. This team can be involved in care planning and can facilitate complex case reviews for individuals. In-patient services and CMHTs can refer into the team for advice and a case formulation can be taken.

Cwm Taf University Health Board *(CTUHB) has established a service to deliver Dialectical Behaviour Therapy. The service was developed for people with primarily a diagnosis of borderline personality disorder who require an intensive psychological therapy to overcome high risk self harm and suicide. The service is virtual and has been running for approximately 12 months.*

Abertawe Bro Morgannwg University Health Board *(ABMUHB) and* ***Aneurin Bevan University Health Board*** *(ABUHB) are working with the National Offender Management Service on a newly established community based personality disordered offender pathway. This provides specialist psychological consultation to offender supervisors in relation to offenders with personality disorders, with the aim of enabling offender supervisors to work effectively with such individuals. The aim is to enable them to access mainstream mental health services when necessary.*

Substance Misuse

We have found issues with dual diagnosis in two reviews (Mr H and Mr M). Dual diagnosis relates to those individuals who were also deemed to have substance misuse problems in addition to a mental illness. In particular, we found the care for these individuals to be disjointed and inadequate in terms of meeting individuals' needs.

In 2010, HIW published a report '*Substance Misuse Services in Wales: Are they meeting the needs of service users and their families?.*' Within this report we reported that links between substance misuse and mental health services were considered to be significantly under-developed. We cited several issues as to why we believed this to be the case. These included:

- Unclear lines of accountability which resulted in a lack of responsibility for implementation
- A concern that in practice, joint working can result in one service shifting responsibility for service users onto the other

- A lack of understanding about how service users with varying degrees of need should be treated and which agency would be expected to take the lead.

Our findings from the homicide reviews have suggested that the issues listed above remain relevant. The prevalence of dual diagnosis, and the implications it has for mortality[14], serves to highlight the importance of improving the co-ordination of services required to tackle these problems.

Welsh Government published the '*Service Framework for the Treatment of People with Co-occurring Mental Health and Substance Misuse Problem*'[15] in 2015, replacing the prior 'Service Framework to Meet the Needs of People with a Co-occurring Mental Health and Substance Misuse Problem (2009)'. This was published in 2015 partly as a result of HIW's 2010 report. If implemented, we are confident that the new service framework will aid with resolving some of the issues in relation to dual-diagnosis.

Medication Compliance

In two reports (Mr F and Mr L), we raised issues relating to individuals living in the community and how their medication compliance was being monitored. Monitoring compliance with medication post-discharge is a challenge, particularly for individuals who may not choose to engage with services. However, adequate systems should be in place to monitor compliance. Whilst compliance with medication is normally monitored through medication reviews with GPs, we found this to be inconsistent in in the two reviews cited. In the case of Mr F, despite his '*erratic and sporadic*' attendance at a Lithium Clinic no assertive action was taken to check that his Lithium levels were consistent. In the case of Mr L, despite a documented history of issues with his non-compliance with his medication, we found that weaknesses in care coordinator arrangements had a clear negative impact upon medication compliance.

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[14] The *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report (July 2014)* identified that in Wales between 2001 and 2012 there were:
• 387 suicides in people known to services with a history of alcohol misuse, 48% of the total sample
• 275 patient suicides with a history of drug misuse, 34% of the total sample
• 460 patients who had a history of either alcohol or drug misuse or both, 56% of the total sample
• 119 patient suicides had severe mental illness and co-occurring alcohol or drug dependence/misuse (dual diagnosis), 15% of the total sample

[15] Link: http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/publications/substance-misuse/?lang=en

Discharge and Aftercare Planning

Discharge arrangements and aftercare has been a common theme running across six of our reviews (Mr F, Mr H, Mr I, Mr J, Mr L and Mr M). We found the standard of documentation poor in several cases and limited information was shared with relevant parties in relation to relapse indicators. This is particularly significant, as most of the individuals examined during the course of our reviews had a history of relapse, history of repeat admissions and reluctance to engage with services.

We have highlighted concerns in relation to individuals being discharged from hospital back into the community and how these were managed. In most cases, individuals were discharged without discharge summaries and/or contingency plans were not forwarded to the relevant parties, for example GPs. This impacted on continuity of care and understanding.

In some cases (Mr F and Mr L) follow-up care was attempted by secondary mental health services. However, this was disjointed, particularly when individuals were reluctant to engage with services. Discharge arrangements were less than organised and did not follow an accepted pathway of care as set out in CPA or the Measure[16] (relevant to Mr M only).

In some cases (Mr F, Mr H, Mr J, Mr L and Mr M) we found that there was a lack of an effective Multi Disciplinary Team (MDT) approach to taking decisions about an individual's discharge from services. Furthermore, the reasoning behind the discharge was not clearly documented and there was a lack of joint working and sharing of information underpinning discharge decisions. It is important that

[16] The Code of Practice looks at a person's discharge from secondary mental health services. It requires the relevant authority, whether Health Board or Local Authority, to provide the person with clear information about why the secondary care service is ending and where future support may be accessed. Importantly the person must also be informed of their right to a further assessment under Part 3 of the Measure. The aim of Part 3 of the Measure is to make it easier for people who are not currently receiving secondary mental health services, but have done so in the previous three years, to access those services again. It gives them the right, if they believe their mental health is deteriorating to the point where they need specialist care and treatment again, to refer themselves directly back to secondary services, without first having to see a GP or go elsewhere for a referral.
This part of the Measure puts a duty on Local Health Boards and Local Authorities to have arrangements in place to respond to such self-referrals, and to undertake timely assessments.

discharge planning is properly managed so that an individuals' recovery process is not compromised.

In the sole case (Mr I) that examined aspects of prison healthcare, arrangements needed to be strengthened in relation to discharge from prison, including compliance with Prison Mental Health Pathway[17] guidance to ensure effective MDT discharge planning.

> ***Abertawe Bro Morgannwg University Health Board*** *(ABMUHB) told us that as a result of recent reviews into homicides committed by mental health service users, the ABMU's prison in-reach teams have established clearer protocols for liaising with community mental health teams, GPs and offender supervisors. This ensures that details of mental health interventions with prisoners are shared prior to release.*

Integrated and co-ordinated services

In the sections above, we have set out the importance of coordination of services, in particular when completing an individual's care and treatment plan. We found that central to the effective management of patient care pathways is the integration of the services that are being provided to individuals. Most of our reviews have highlighted issues in relation to this, with the main area of concern relating to the effectiveness of the management of secondary mental health services by the CMHTs.

Effective leadership and management of CMHTs emerged as a common finding in eight of our reviews (Mrs A, Mr B, Mr E, Mr D, Mr M, Mr F, Mr G and Mr L). Particular issues related to how the multi-disciplinary teams work together and how patients are managed and supervised. During several of our reviews we found a need to strengthen the integration of both health and social care staff within CMHTs and the need for organisations to ensure that each CMHT has clear overall clinical and managerial leadership.

Our reviews have demonstrated that CMHTs also need to develop and implement effective and robust caseload management policies and processes. In some reviews (for example, Mr L) the lack of effective leadership at CMHT level led to significant issues in relation to the large size of workloads/caseloads, team capacity and performance management.

[17] Prison Mental Health Pathway for Wales (2006)

Many of the reviews commented on a lack of effective joint working within the CMHTs and how this had had an adverse impact on the care and treatment provided to individuals, especially those who were demanding or had complex needs. It has been concerning to note how often we found that there had been a lack of effective oversight of an individual's care and treatment when on a CMHT's caseload.

Communication and Information Sharing

Communication and information sharing is a significant theme that has remained constant across our 13 reviews. Communication is a broad theme and in many senses all of the themes highlighted by this evaluation could be encapsulated by this heading. However, our analysis suggests that key issues such as appropriate information sharing between and within organisations, and between professionals has had a significant impact on the quality of care and treatment provided to patients.

In particular, we have been concerned to note the lack of effective processes or even a mutual understanding of the importance of the timely sharing of information either between, or within organisations, and externally with other relevant agencies or interested parties. We have found inconsistency with how effectively MDTs have operated and functioned. In many cases we have found that due to lack of effective information sharing, MDTs were tasked with making decisions without all relevant information to inform those decisions.

We have also routinely found inconsistency in the communication arrangements between community mental health teams (CMHTs or Crisis Resolution Home Treatment[18] teams [CRHT]) and GPs. Additionally there have also been cases (for example Mr J) where there has been ineffective communication/information sharing between Accident and Emergency departments, GPs, Social Services, the Criminal Justice Service and the Police. In all of these instances, the lack of effective communication has been deemed to be a detrimental factor in the standard of care that has been provided to individuals.

Furthermore, we have queried in some reviews the effectiveness of established information/intelligence forums, such as MAPPA, due to pertinent information either not being shared with or from these forums in a timely fashion, or sometimes information not being up to date. This had a knock on effect on care and treatment

[18] CRHT: A team of mental health professionals who can support an individual at their home during a mental health crisis. It usually includes a number of mental health professionals, such as a psychiatrist, mental health nurses, social workers and support workers.

decisions taken for individuals. For example, in one case (Mr I), health representatives, who had not had any previous involvement with the individual, attended a MAPPA meeting; however, they did not alert the other agencies that the individual was due to be released from prison imminently.

> ***Abertawe Bro Morgannwg University Health Board*** *(ABMUHB) now has a criminal justice liaison team that includes representation at all MAPPA level 2 and 3 meetings, as well as a presence at Courts, which is also integrated with the prison in-reach mental health teams. The team has recently established a process for liaising with victims where Victim Liaison Officers are not involved via probation. The criminal justice liaison service facilitates communication with and signposting to community mental health services as well as offering advice to MAPPA meetings and the criminal justice agencies.*

Whilst the processes for sharing information between mental health services and other organisations needs to be improved, the ability to access information within mental health services also needs to be strengthened. One significant barrier is that information about patients cannot currently be accessed (via IT systems) or shared between CMHTs throughout Wales.

We found that the quality of the information recorded by services needs to be improved. For example, we found that individual's records were not always integrated, which hindered the effective management of their care (Mr F and Mr M). We also found that records (care plans, assessments, discharge summaries) were not always fully complete, strengthening the need for regular monitoring and audit. Records should be accurately recorded and reviewed (particularly to aid with the detection of any patterns in relation to an individual's risk) and should be in line with professional guidelines[19]. These guidelines state that 'good record keeping helps to improve accountability and shows how decisions related to patient care were made'.

In addition, there were problems across the reviews in relation to communication systems, records management and routine analysis of patient history. Weaknesses were found in relation to the sources used for patient history taking (over reliance on 'self- reporting') and a lack of basic documentation being made available to all parties, whether this be internally within health services, or with external partners and agencies. Methods for conveying this information were not formalised and

[19] See: http://www.nhsprofessionals.nhs.uk/download/comms/cg2%20-%20record%20keeping%20clinical%20guidelines.pdf

information was often difficult to obtain depending on the type and number of individual patient records that were being held. In general, evidence of arrangements or protocols for the sharing of information and opinions between agencies was weak with a lack of definitive procedures being adhered to which could lead to gaps in the patient care pathway. This in particular could delay the development of a comprehensive care and treatment plan for individuals.

We found that services had difficulties in engaging with nomadic individuals, who were often living in temporary accommodation or within hostels run by the voluntary sector. Input from a care coordinator attached to the CMHTs, who would visit individuals regularly and see them in their own homes, was often missing due to the difficulty in engaging with these individuals (for example, in the case of Mr K). Care Coordinator's have a vital role in linking the homeless services with those of the CMHTs. Regular visits (as outlined in the Code of Practice for Parts 2 and 3 of the Measure) to the hostels/temporary accommodation would allow the hostel keyworkers to pass on and share information to the care coordinator about the individuals who resided there. In many cases, the keyworkers had vital information and intelligence about individuals' mental state which could have been passed on to the CMHT or any mental health professional.

Our findings have highlighted just how important the key role of care coordinator is, and how ineffective care coordination can have a detrimental impact on the care provided to individuals. The Measure also places a strong emphasis on the role of care coordinators. The Code of Practice states that a person's care coordinator will be key, if not the key professional working with them in secondary mental health services.

We are unable to judge definitively from our reports whether care coordination has improved since the introduction of the Measure. This is because we have only examined one review since its implementation (Mr L), and the vast majority of that individual's care was provided under the previous CPA. In this case we found Mr L had not been assigned a care coordinator at all. Following the implementation of the Measure we expect to see an improvement in this aspect for any future review that we undertake.

5. Assessing the impact of our reviews

As part of this evaluation exercise, we sought feedback from stakeholders regarding what impact our reviews have had on services, why these common themes keep arising, and also to understand how we may improve our own processes when undertaking reviews.

The impact of our reviews

In terms of assessing the impact that our reports have had on mental health services, feedback from those we spoke to as part of this evaluation exercise was varied.

Some organisations that we spoke to, and which were not the direct subject of a review, had established their own internal process to look at the recommendations from each report, regardless of health board area. These organisations had sought to build on the learning from these reviews, taking action within their own organisation if applicable. This is encouraging to note and we would consider this approach to be good practice.

However, other organisations told us that they had no formal process or mechanism in place to ensure wider learning from our reports. This is disappointing as HIW seeks to emphasise that these reviews should be noted and acted on by all health boards, as applicable, in order to ensure that the issues highlighted are prevalent across Wales.

We were told that one of the barriers to the implementation of our recommendations has been when the issues relate to multiple organisations. In an attempt to aid the implementation of recommendations that may span many agencies, including non-health stakeholders, HIW has developed, in conjunction with Public Health Wales (PHW), a 'duty to cooperate'. This is a memorandum of understanding used as a mechanism to ensure that all the stakeholder organisations cooperate with the review process and agree to implement the resultant recommendations. This approach was piloted for one of our reviews[20] and owing to its success, it will be used on all future homicide reviews.

Stakeholders told us that some of the issues highlighted across our reviews were felt to be Wales-wide – for example cultural issues that may take time to change. As

[20] Mr J and the Provision of Mental Health Services, following a Homicide committed between February- March 2010 – published in September 2013

such, we were told that these recommendations could be better addressed if tackled from a national perspective, with the driver for change coming from either HIW or Welsh Government. Some examples that were cited as all-Wales issues were:

Communication / Information sharing

Sharing of information both between services within a health board area and with other health boards across Wales. Due to organisations operating with differing information technology systems, the ability to access information, such as that relating to a patient receiving treatment in one health board area whom has previously received treatment in another, is difficult and hinders assessment.

Family Engagement

Difficulties have been encountered in regards to understanding what information can be shared and with whom. Most stakeholders have informed us that they would welcome Welsh Government guidance regarding this, not only to improve family engagement but to also protect staff in regards to potential data protection issues.

Personality Disorder

Complexities encountered by stakeholders in regards to the provision of services and staff training in order to best assist those individuals diagnosed with a personality disorder.

Stakeholders proposed that where HIW has issued a series of recommendations across single or multiple reviews that are applicable on an all-Wales basis that HIW could focus on these specific themes in more detail as part of its overall programme of work. The intended result being that a more specific focus on these issues would help drive improvements and tackle nationwide issues.

One suggested approach was that HIW may consider holding an annual ‘event’ to feed-back on issues emerging from our reviews and all-Wales applicable recommendations. HIW currently works in partnership with PHW on the Untoward Incidents National Steering Group. The Group was established by Health Boards in 2012 to lead and coordinate an improvement programme on untoward incidents in mental health and related services to people of all ages, including homicides and other serious untoward incidents. One of the key purposes of this group is to act as a regular mechanism for sharing learning. Whilst HIW has presented themed outcomes from its homicide reviews at this group, it is an area in which further work can be done in order to aid wider learning from our reviews.

HIW's review process

We received universal feedback from stakeholders suggesting that the homicide reviews carried out by HIW are invaluable and should continue.

We were told that although reports can be lengthy, the level of detail contained within them was important in providing context and justification for the subsequent findings and recommendations. Those stakeholders who were directly involved in earlier review processes requested that an executive summary be included within future reports to aid readability. However, all of HIW's reports published since 2014 have included an executive summary. HIW intends to continue with this approach.

It also came to our attention that reports were not routinely being circulated to all stakeholders and on the occasion that they were, they had not always been shared with the relevant individuals. It is apparent that HIW needs to ensure that it holds an accurate and up-to-date list of stakeholders and interested parties to ensure that the homicide reviews are shared amongst appropriate organisations to assist shared learning and best practice. However, it is also important that Welsh Government, as commissioners of these reviews, ensures the wider impact and learning from these reviews is taken forward across all health boards.

Stakeholders also shared their concerns regarding the timescales set out by HIW for the production of action plans addressing report recommendations. It was felt that the timescales are often too short and not enough consideration was given to the need for discussions with other organisations involved, to enable them to formulate joint action plans that were achievable and meaningful. HIW accepts this feedback and will seek to improve its process to support the development of recommendations. One mechanism that will hopefully aid in addressing this issue is that HIW intends to schedule 'Facilitated Learning Events' for all future reviews. These are modelled on the approach taken by Child Practice Reviews in Wales[21].

A Facilitated Learning Event will be held post fieldwork and include all key stakeholders from the review process. This will provide an opportunity for all stakeholders to share and discuss the issues that have emerged from the review, fostering a greater understanding of the context behind HIW's findings. These events will also be used to help identify recommendations and thus enable stakeholders to have much earlier joint discussions to aid the production of action plans.

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[21] See: http://www.sewsc.org.uk/fileadmin/sewsc/documents/Published_SCR_CPR/Child_Practice_Review_Guidance_-_Welsh_Government.pdf

The Role of Welsh Government

As part of this evaluation we were also given feedback regarding the role of Welsh Government in relation to the commissioning of reviews, the implementation of recommendations and ensuring wider learning from our reports.

Stakeholders expressed to us a lack of clarity as to why HIW is commissioned to undertake some reviews and not others. Whilst telling us that they believe that HIW should continue carry out such reviews, stakeholders expressed a wish for more openness and transparency from Welsh Government in terms of the reviews it does *not* commission HIW to undertake. Welsh Government told us that decisions regarding whether an independent external review is commissioned are made on a case by case basis dependent upon many factors, such as findings from the health board's own internal investigation, the proportion of time the perpetrator spent in contact with mental health services, and consideration of judicial proceedings.

However, stakeholders told us that they believed that Welsh Government should consider providing greater clarity in relation to the criteria and process behind the decisions taken to request an independent external review.

Welsh Government's view

Feedback from Welsh Government regarding the impact and importance of our reviews was positive. We were informed that the level of detail with which we conduct the reviews is seen as a particular strength, complemented by how open and transparent we are in presenting our findings. Welsh Government informed us that this aspect is particularly important in terms of providing assurance to those affected by such tragic events, in particular the demonstration that we have been objective and open in conducting our work. Welsh Government also told us that it is currently exploring how to use the work undertaken by HIW to inform health policy more effectively.

It is clear that much work is being undertaken by Welsh Government in relation to mental health, with the *Together for Mental Health*[22] strategy currently out for consultation. Welsh Government has also recently launched the new '*Talk to Me 2*' strategy which follows up '*Talk to Me*' which was published in 2009. Talk to Me 2

[22] See: http://gov.wales/topics/health/nhswales/healthservice/mental-health-services/strategy/?lang=en

focusses on suicide and self harm prevention and shares some common ground with HIW's own work in that our reviews highlight circumstances where individuals posed as great a risk to themselves as they may have to others.

A further example of activity in this area is the *Crisis Care Concordat*[23] for Wales which also aims to substantially decrease the number of individuals who are held in police cells when they experience a mental health crisis. We were informed that there are plans in place for the development of standards for crisis intervention teams in both mental health and learning disabilities. These standards will set out in detail what care should look like for individuals who have the potential of harming themselves or others.

Whilst there is much work being done on a national level to address and improve mental health services, our evaluation highlights that even more can be done to learn from and address the common themes found in our reviews.

[23] See: http://gov.wales/docs/dhss/publications/151210reporten.pdf

6. Conclusion

This evaluation has highlighted a number of key themes and findings across the 13 homicide reviews undertaken since 2007.

It is imperative that more work is done to ensure the issues that cause these themes to keep emerging across our reviews are addressed; some of that work is the responsibility of the organisations providing the services to individuals with mental health needs. However some of the responsibility in terms of sharing the wider themes and learning from these reviews also lies with HIW and Welsh Government respectively.

This exercise has provided a valuable opportunity for HIW to gain feedback from stakeholders on ways in which it can improve the delivery of homicide reviews. Stakeholder comments have been noted and many of the issues raised have already, or are in the process of being addressed. We are continually seeking to evolve our programme of work to focus on impact and ensure that we follow-up on issues that we find during the course of our work. We will use the findings of this report alongside the intelligence we receive from external organisations and stakeholders to target our future inspection activity as appropriate.

There is evidence to suggest that HIW's homicide reviews are valued by and beneficial to both services and those involved in delivering care and support to individuals with a mental health condition. However, further work is required in order to strengthen the impact of our work and the means by which the issues that emerge from these reviews are acted upon by all health boards.

7. Appendix A

HIW Methodology

HIW undertook an exercise evaluating the 13 reviews that have been published to date. The purpose of the evaluation was to:

- Undertake a detailed analysis of the findings and recommendations identified in all homicide reviews
- Identify whether there were common theme/s to recommendations
- Assess the impact the reports, and the recommendations issued since 2007, have had on services that are being provided to mental health service users
- Engage with services and stakeholders to identify potential barriers to improving services, implementing change, and barriers and issues that prevent effective partnership working
- Identify the benchmark for improvement and examples of best practice on a national basis, and consider how best practice may be effectively shared
- Produce recommendations for referral to the appropriate forum, new or existing
- Identify what learning HIW can take forward in regards to its own processes
- Identify areas of improvement and learning to be taken forward by stakeholders
- Publish a public report presenting the outcome of this evaluation review

Our review consisted of three different phases.

Phase 1

Detailed analysis of the 13 reports produced by HIW.

Phase 2

Engagement with stakeholder organisations, including meetings and discussion with these interested parties.

Phase 3

Identifying key findings and report writing.

In undertaking our review we have ensured engagement with stakeholders in order to obtain their contribution towards the evidence base for this evaluation. HIW liaised with stakeholders to raise awareness of review arrangements to help facilitate fieldwork arrangements. HIW wrote to all health boards, local authorities and engaged with:

- Welsh Government – Department for Health and Social Services
- Abertawe Bro Morgannwg University Health Board
- Aneurin Bevan University Health Board
- Cardiff and Vale University Health Board
- Hywel Dda University Health Board
- Cwm Taf University Health Board
- Powys Teaching Health Board
- Blaenau Gwent County Borough Council
- Carmarthenshire County Council
- Wales Alliance for Mental Health
- National Offending Management Services (NOMS) in Wales

8. Appendix B

Reports considered as part of this review

The reports considered as part of this review are:

1. Report of a review in respect of Mrs A and the Provision of Mental Health Services, following a Homicide committed in October 2005 – published in May 2008.

2. Report of a review in respect of Mr B and the Provision of Mental Health Services, following a Homicide committed in April 2006 – published in May 2008.

3. Report of a review in respect of Mr C and the Provision of Mental Health Services, following a Homicide committed in October 2006 – published in October 2008.

4. Report of a review in respect of Mr D and the Provision of Mental Health Services, following a Homicide committed in March 2007 – published in November 2009

5. Report of a review in respect of Mr E and the Provision of Mental Health Services, following a Homicide committed in August 2007 – published in October 2009

6. Report of a review in respect of Mr F and the Provision of Mental Health Services, following a Homicide committed in December 2008 – published in November 2010

7. Report of a review in respect of Mr G and the Provision of Mental Health Services, following a Homicide committed in May 2009 – published in January 2011

8. Report of a review in respect of Mr H and the Provision of Mental Health Services, following a Homicide committed in March 2009 – published in June 2011

9. Report of a review in respect of Mr I and the Provision of Mental Health Services, following a Homicide committed in June 2009 – published in November 2011

10. Report of a review in respect of Mr J and the Provision of Mental Health Services, following a Homicide committed between February- March 2010 – published in September 2013

11. Report of a review in respect of Mr K and the Provision of Mental Health Services, following a Homicide committed in March 2011 – published in April 2014

12. Report of a review in respect of Mr L and the Provision of Mental Health Services, following a Homicide committed in October 2012 – published in September 2014

13. Report of a review in respect of Mr M and the Provision of Mental Health Services, following a Homicide committed in May 2011 – published in November 2014