Tees Esk and Wear Valleys NHS Foundation Trust

Thematic Review of 15 Serious Incidents relating to patients on leave during the period February 2015- October 2016

Final Draft

8.02.2017

Acknowledgements

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Report prepared for Tees, Esk and Wear Valleys NHS Foundation Trust, by the North of England Mental Health Development Unit Ltd.

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1. Background and Context

Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) are committed to proactive governance in supporting high standards of patient safety. As a result of an internal discussion at Executive level, it was identified that a number of serious incidents were related to people who took their own lives or suffered serious harm while on a period of leave from in-patient care. TEWV identified a need to use skilled analysis to support moving the focus of discussions from the acts or omissions of staff or systems, to identifying the learning opportunities. This led to a decision to undertake a review to consider whether there were any specific themes apparent relating to these incidents.

The North of England Mental Health Development Unit (NEMHDU) was requested to carry out this review in light of their significant experience in supporting NHS Mental Health Trusts to develop high standards of governance through access to strategic, operational and academic expertise, as well as experience in the field of governance regarding serious untoward incidents. This, coupled with NEMHDU's independence, was felt would give additional credibility to the review.

Following the start of this review the Care Quality Commission (CQC) highlighted more broadly the importance of Serious Untoward Incident (SUI) investigations within the overall governance framework of NHS Trusts[1]. This review therefore will form an integral part of the Trust's overall strategy for learning from untoward incidents.

About the delivery organisation

The North of England Mental Health Development Unit (NEMHDU) is a social enterprise which:

- Provides strategic leadership in mental health;
- Upholds the values of service user and carer involvement; and
- Reinvests into the mental health community in the North of England

NEMHDU has established a core project team to ensure the best use of its access to a wide range of expertise. The project lead is a former Executive Director of Nursing at an NHS Foundation Trust. He has extensive experience in corporate and professional governance, specifically including health and social care independent case reviews relating to serious untoward incidents, across a range of organisations and settings.

The project team also included academic research colleagues, a senior nurse with extensive experience of service user and carer involvement, and a colleague with process and system improvement expertise, both at local, regional and national levels.

[1] Learning, Candour and Accountability; a review of the way NHS Trusts review and investigate the deaths of patients in England; CQC (Dec 2016)

2. Methodology

The project reviewed information against key criteria from each patient incident to enable trends and themes to be identified. This comprised a multi-stage approach consisting of both quantitative and qualitative data collection.

Phase 1:

This phase focused on the development of a set of criteria against which the identified cases would be reviewed. This quantitative data was determined and informed by a combination of those criteria used within the National Confidential Inquiry[2], NEMHDU expert knowledge of SUI investigations and local criteria determined through the active involvement of senior clinicians via a focus group. Initially the project team formulated a set of criteria, which was then agreed and expanded by a group of 16 senior clinicians identified by the Trust from a broad range of in-patient areas. The facilitated focus group took place on 8th November 2016 and provided the final criteria by which the next phase of work was undertaken (see Appendix 1).

Whilst it was also proposed to hold a focus group with service user and carer representatives from the Trust Board of Governors, due to unforeseen circumstances the planned workshop was postponed at short notice and was unable to be reconvened within the project timescales.

During this phase a scoping exercise was carried out which identified salient policy guidance and reports in order to provide contemporary context for the review. A summary of this information is provided in section 3 of this report.

Phase 2:

15 serious untoward incidents were identified by TEWV involving patients on leave from in-patient care, during the period 2015-16. Of the 15 cases, 12 resulted in death as a result of suicide (this is inclusive of open and narrative determinations). The project team undertook a thorough analysis of the incident reports relating to these 15 incidents. Demographic and clinical information regarding each case was identified, collated and analysed. All data was anonymised. The project team extracted the data available against the agreed criteria from the incident reports and then worked in partnership with the Trust's Patient Safety team to provide as complete a data set as possible. It has not been possible to identify data against all of the criteria and where relevant this is identified in Appendix 2. No additional cross-checking or triangulation of the incident reports occurred, i.e. clinical records or other patient specific information was not accessed.

[2] Available at: http://www.bbmh.manchester.ac.uk/cmhs/centreforsuicideprevention/nci/reports/Annualreport2014.pdf

As part of the focus group with clinicians, data triggers were identified which would lead to a more in depth examination of an incident. This more in depth examination would take the form of a learning review meeting (LRMs). Six learning review meetings were identified and undertaken as part of the project, allowing clinical staff to contribute important information to the analysis based on their own experiences. The framework for the learning review discussions, which was informed by previous phases of the work, is included at Appendix 3 for information.

3. Scoping Exercise: Policy Guidance and Reports

In order to support the project team to undertake a current and contemporary review, it was felt necessary to consider relevant guidance, policy and context. It was felt by the project team that a summary of this information would be of benefit to anyone reading this report. What follows is a brief overview of the documents considered.

Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England; ***Care Quality Commission; December 2016***
A year after a review commissioned by NHS England uncovered failings at Southern Health Foundation Trust, the CQC looked at how acute, community and mental health Trusts across the country investigate and learn from deaths of people who have been in their care. They looked at the processes and systems Trusts use to identify, investigate and learn from the death of a person using their services. They looked particularly closely at how Trusts investigate the deaths of people with a mental health problem or learning disability.
The CQC weren't able to identify any Trust that demonstrated good practice across all aspects of identifying, reviewing and investigating deaths, and ensuring that learning is implemented. But they saw some Trusts demonstrate promising practice at individual steps. They CQC focused on five key areas: (1) Involvement of families and carers; (2) Identification and reporting; (3) Decision to review or investigate; (4) Reviews and investigations;
(5) Governance and learning
CQC recommendations are summarised as:

- Learning from deaths needs much greater priority within the NHS to avoid missing opportunities to improve care.
- Bereaved relatives and carers must receive an honest and caring response from health and social care providers and the NHS should support their right to be meaningfully involved.
- Healthcare providers should have a consistent approach to identifying and reporting the deaths of people using their services and share this information with other services involved in a patient's care.
- There needs to be a clear approach to support healthcare professionals' decisions to review and/or investigate a death, informed by timely access to information.
- Reviews and investigations need to be high quality and focus on system analysis rather than individual errors. Staff should have specialist training and protected time to undertake investigations.
- Greater clarity is needed to support agencies working together to investigate deaths and to identify improvements needed across services and commissioning.
- Learning from reviews and investigations needs to be better disseminated across trusts and other health and social care agencies, ensuring that appropriate actions are implemented and reviewed.

- More work is needed to ensure the deaths of people with a mental health or learning disability diagnosis receive the attention they need.

http://www.cqc.org.uk/content/learning-candour-and-accountability

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review; *University of Manchester; October 2016*

This report provides the latest figures on tragic events – suicides, homicides and sudden deaths – and highlights the priorities for safer services. It aims to reflect the concerns of patients, families and staff; this report highlights acute care, economic adversity and recent migrants. It also looks back on 20 years of data collection, drawing on previous reports and journal papers. What have we learned? How has the challenge of managing risk changed? From studies of mental health services, primary care and accident and emergency departments, this report presents the essential evidence-based elements of safer care. Whilst there is no specific focus on suicide by patients on leave, the report does look at in-patient suicides and states: "Suicide by mental health in-patients continues to fall, most clearly in England where the decrease has been around 60% during 2004-14. This fall began with the removal of ligature points to prevent deaths by hanging but has been seen in suicides on and off the ward and by all methods. Despite this success, there were 76 suicides by in-patients in the UK in 2014, including 62 in England."

This report informed the initial set of criteria used to carry out the thematic review of serious incidents relating to patients on leave within Tees, Esk and Wear Valleys NHS Trust and has also been used to provide national data comparators.

http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

Learning from serious incidents in NHS acute hospitals; *Care Quality Commission Briefing; July 2016*

The issue of serious incident investigation is not unique to mental health services as evidenced by this recent CQC publication, which discusses the need for a change in the way that serious incidents are investigated and managed in the NHS. It is based on the findings of a review of a sample of serious incident investigation reports from 24 acute hospital trusts. This sample represented 15% of the total 159 acute hospital trusts in England at the time of review.

The CQC briefing provides a summary of findings, linked to 5 opportunities for improvement and calls for all acute organisations to work together across the system to align expectations and create the right environment for open reporting, learning and improvement.

Five opportunities for learning:

1. Serious incidents that require full investigation should be prioritised and alternative methods for managing and learning from other types of incident should be developed.
2. Patients and families should be routinely involved in investigations.

3. Staff involved in the incident and investigation process should be engaged and supported.
4. Using skilled analysis to move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident.
5. Using human factors principles to develop solutions that reduce the risk of the same incidents happening again.

http://www.cqc.org.uk/content/briefing-learning-serious-incidents-nhs-acute-hospitals

Five-Year Thematic Review of Suicides by People in Contact with AWP Services 2008-12; *Avon and Wiltshire Mental Health Partnership NHS Trust; April 2015*

This review is an attempt to explore and understand some of the data concerned with Avon and Wiltshire Partnership Trust's (AWP) statutory and contractual reporting of the range of actual and suspected suicides of people receiving care from AWP between 2008 and 2012. AWP wanted to identify whether there were any particular trends or themes that emerged from exploring the data as a whole. Wherever possible they attempted to make comparisons with published regional and national data relating to suicide.
http://www.awp.nhs.uk/news-publications/trust-news/2015/september/thematic-review-of-suicides-2008-2012-published/

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
http://www.cqc.org.uk/content/regulation-20-duty-candour#full-regulation

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry; *Francis, R., 2013*

It is important to emphasise that strong clinical governance is at the core of health care provision; it is fundamental to the delivery of safe, effective, person centred and high quality care. This has never been as prominent in the NHS as can be demonstrated by the publication in 2013 of the Francis report.
Francis stressed the importance of avoiding a blame culture, in order to encourage staff to be open and honest and therefore learn lessons from incidents.
http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/

Preventing suicide: a toolkit for mental health services; *National Patient Safety Agency/ National Reporting and Learning Service, November 2009*

The suicide prevention toolkit, updated in 2009, provides mental health organisations with a simple method to:

- establish a system for suicide audit in the local context
- use case note reviews to change how performance is measured and risks are identified
- support the development of local suicide prevention strategies
- produce data which can be merged at regional and national levels to identify trends for further learning

http://www.nrls.npsa.nhs.uk/resources/?entryid45=65297&q=0%c2%acsuicide%c2%ac

Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services: Document prepared for the National Mental Health Risk Management Programme, *Department of Health, March 2009*

The guidance contained in this document was first issued in June 2007. The 16 Principles of Best Practice in managing risk in mental health services were welcomed and have underpinned significant and positive developments in many trusts across England. Since June 2007, the team who developed the guidance have been involved in various projects supporting its national implementation. The guidance has now been updated and republished with information about its implementation. Appendix 6 is a major addition to the document issued in June 2007. In this appendix, there is information about the implementation project. There is also information and support for trusts who want to assess how well practice in their locality meets the standards set – and to make improvements to clinical risk assessment and management practice in their area.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

An organisation with a memory: Report of an expert group on learning from adverse events in the NHS; *Department of Health, 2000*

The Department of Health recognise that things can go wrong even when best practice has taken place. If things do go wrong, or do not go according to a documented plan, it is important to learn why. This report examines the key factors at work in organisational failure and learning, a range of practical experience from other sectors and the present state of learning mechanisms in the NHS before drawing conclusions and making recommendations.

http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4065083

4. Findings

Whilst formulating the findings the team has tried wherever possible to use comparable data in order to provide a context. However, there is currently no comparable data set for serious untoward incidents while patients are on leave, nor is there a specific data set for completed suicide whilst on leave. The team have therefore only used comparator data when it has seemed reasonable to do so, and/or provides a useful context for local findings. It is therefore important to re-iterate of the 15 cases, 12 resulted in death as a result of suicide (this is inclusive of open and narrative determinations).

In considering the geographical perspective, it is worthy of note that Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby suicide rate of 12.1 per 100,000 population represents the 3rd highest suicide rate of the 44 Sustainability and Transformation Planning (STP) footprints in England; the highest rate being 13.8 (Cornwall and the Isles of Scilly) and the lowest 6.9 (South West London). Coast, Humber and Vale STP, of which York and Selby are part, had a suicide rate of 10.6 per 100,000 which represents the 13th highest STP rate.

In moving from the broader position within the general population, as represented by the STP data to that of specific relevance within this study, ie. In-patients within a psychiatric setting, the National Confidential Inquiry into suicide and homicide by people with mental illness[3] is a useful information source. This is relevant as clearly through definition all patients on leave are on leave from an in-patient episode within their individual care pathway. The National Confidential Inquiry states "the number of suicides by psychiatric in-patients in the UK has shown a large and steady fall since our early years of data collection, a fall of 69% from a peak in 2000 to the estimated figure for 2014. The fall has been particularly marked since 2003. The fall mainly reflects the fall in England where there has been a 68% decrease in in-patient suicides since the data collection began. During this period (i.e. since 1998) data from the Health and Social Care Information Centre (HSCIC) showed the number of beds fell by 40% and the number of admissions by 20%, much less than the fall in suicides. In a previous study we confirmed that there had been a fall in the rate as well as the number of in-patient suicides, i.e. taking into account the reduced use of beds."

Strategic organisational development over recent years has enabled the provision of a range of specialist in-patient mental health services across a number of localities served by TEWV. During the period under review there was a change in the provider of in-patient services for the population of York & Selby. The provision of this service moved from Leeds and York NHS Foundation Trust to TEWV. Between October 2015 and October 2016 no local acute admission beds were available in the York/Selby area resulting in the patients being admitted into other acute admission beds in other Trust localities. The breakdown of

[3] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness; Making Health Care Safer: Annual Report and 20-year Review; University of Manchester; para 271-272 (Dec 2016)

At a local level, Clinicians at the focus group considered this matter an important area to also explore within the Learning Review Meetings. There was a consensus view expressed that demonstrated a perceived significance of the staffing situation during the period incidents took place. Whilst the specific question relating to the staffing situation was considered at each Learning Review Meeting, a census of the staffing position was also undertaken relating to the sample group (all 15 incidents).

What was evident from one of the learning review meetings was the issue of illicit drug use, including new psychoactive substances (NPS), often referred to as legal highs. There was a view these impacted on the ward environment in the context of their disruptive influence and impact negatively on the amount of therapeutic time available to staff. However, in the remaining learning review meetings staffing was not felt to be an issue.

Furthermore, in 4 of the incidents discussed at the learning review meetings, there was not felt to be an unusual amount of activity which placed additional demands on staff, for example, the number of people on special observations.

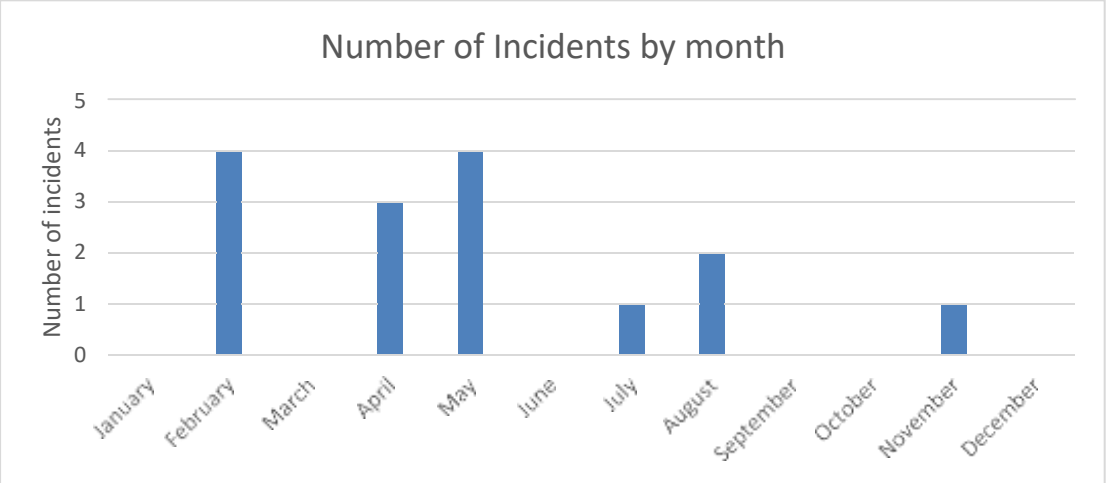
Figure 4 on the following page identifies the results of the census, demonstrating the difference between planned staffing levels for qualified and unqualified staff and the actual hours on the day of each incident.

- There were 3 occasions where the total staff hours were below that which was planned.
- On 4 occasions there was a lower number of qualified staff hours than planned.
- On 3 occasions there was a lower number of unqualified staff hours than planned.
- There were no occasions where there was a lower number of both qualified and unqualified staff hours than planned.
- In contrast, on 7 occasions there were more qualified staff hours than planned.
- On 5 occasions there were more unqualified staff hours than planned.
- There was only 1 occasion where there was both more qualified and unqualified staff hours than planned.

From the data obtained figure 4 shows variances from planned staff to actual staff on duty on the day of the incidents. This suggests that where some staff either qualified or unqualified are varied from that planned the Trust has taken action to minimise the impact of any shortfall. It has not been possible to factor in the potential impact of any special observations occurring within each ward on the day incidents occurred as this information was not available.

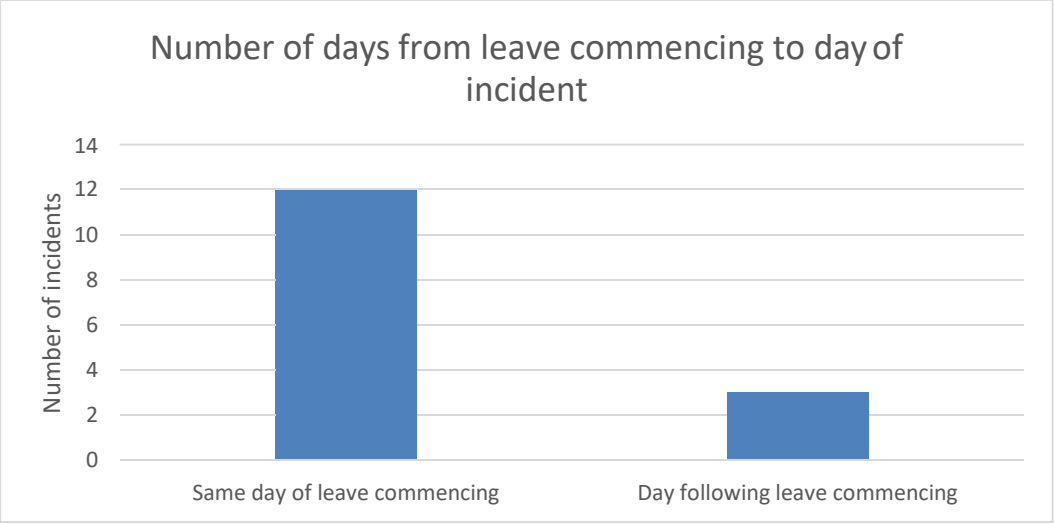
The majority of incidents, as can be seen from Figure 9, occurred between the months of February and May (73%). The latest data for the Northern Region published by the Office for National Statistics (ONS)[7] (relating to 2013) identifies April and May as peak months for suicide in the general population, which does correlate to the incident dates. Within the ONS data December was also a peak month, however there were no incidents in the TEWV sample group recorded in December.

Figure 9: Number of incidents by month



As can be seen in figure 10 below, 12 (80%) of the incidents occurred on the day of leave commencing, the remaining three the following day.

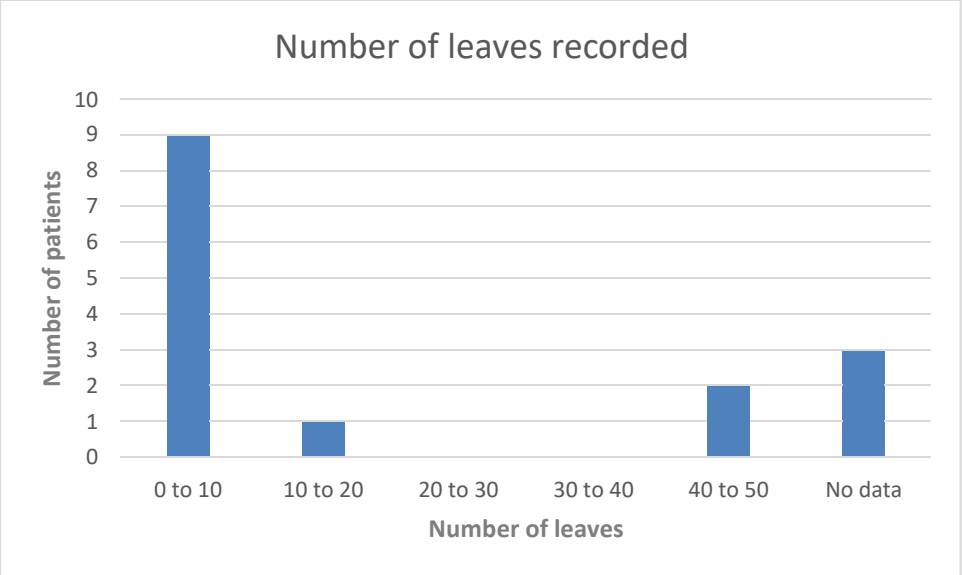
Figure 10: Number of days from leave commencing to day of incident



[7] Number of suicides by month of occurrence, regions of England and wales 1981-2013, Office of national statistics April 2016.

The number of leaves during the current admission prior to the leave episode when the incident occurred are as follows:

Figure 18: Number of leaves recorded during current admission period prior to leave episode when incident occurred



From reviewing the reports there was a lack of consistency in relation to how leave was being determined. In order to arrive at these figures the review team have used the standard detailed in the Trust's policy[10] that relates to when a patient leaves the ward environment.

[10] Leave of absence under Section 17 Mental Health Act 1983 and time away from the hospital, MHA-003-001, v1.1, TEWV, June 2016

5. Analysis

The quantitative information relating to incidents, plus other supporting data obtained from TEWV, in addition to the qualitative data identified through the learning review meetings, has been analysed and as a result four broad themes have been identified which are described as:

Description of themes

Theme 1: Missed opportunities for intervention

This theme has been identified to include core elements associated with the delivery of safe and effective care; the absence or omission of these elements from the person's care pathway on or near the time of the incident are often also associated with an increase in overall risk, and in particular risk of suicide. None of the reports identified a direct causal link between these factors and the person's death.

Theme 2: Opportunities for learning from incident and patient characteristics

This theme includes individual, person-specific items which are known to be associated with an increased risk of suicide. Their identification here did not necessarily indicate that there was a failure by the care team to recognise this association; in the majority of cases these characteristics were identified as part of the assessment and risk management processes.

Theme 3: Opportunities for learning from the ward profiles

Where ward profile data consistently suggests there are categories which, whilst not directly connected with the incident itself, may be indicative of wider organisational issues which may influence ward environment, staff knowledge, skills and policy.

Theme 4: Serious untoward incident review process issues

This theme constitutes the issues noted with the SUI review system itself, whether the process itself requires attention or where the project team feel there are significant issues or gaps.

In order to encourage constructive debate, the review team have provided a more detailed description of the salient points in the table below.

Theme 1: Missed opportunities for intervention

- There are inconsistencies across the incidents reviewed in the classification of leave. Despite clarity in the Trust policy, *Time off the Ward* and *Leave* are repeatedly used interchangeably in the review reports, often for the same type of absence from the ward.

- There does not appear to be a consistent approach to assessing and recording risk in relation to the time of leave commencing (regardless of when the original decision was made). This is particularly evident for those classed as 'informal' patients. There is anecdotal and some data evidence that 'informal' patients and absences from the ward not classified as leave, receive less attention to their risk levels at time of leave/absence. There would seem to be a parallel drawn between legal status and risk, with informal patients often perceived as lower risk than formal patients.

- There is also limited evidence in the review reports of risk assessment taking place at the time of the leave decision. These issues combined represent either an omission from the incident reports or a gap in practice at ward level.

- All but 3 of the incidents occurred on the day of leave commencing, the remaining the following day. This reinforces the importance of risk review not only at the time of the leave decision but also on the day of leave commencing. Additionally, crisis contact information should be provided to the patient and where appropriate the carer.

- A number of the incident reports highlight the lack of information given to carers as an area of concern. This was replicated within carer satisfaction reports.

Theme 2: Opportunities for learning from incident and patient characteristics

- There were a significant number of incidents in the early part of the calendar year.

- The immediate period following leave commencing was significant in that all incidents occurred either that same day or the following day and as such this should be seen as a high-risk period.

- All of the demographic profile data from the incidents is broadly in line with national data sets; gender, age, living arrangements, employment and marital status were all within national ranges.

- In terms of cause of death, jumping/multiple injuries in the incidents reviewed was

Theme 4: Serious untoward incident review process issues

- There is inconsistent use of date coding within the SUI reports with some report authors using the American (month/day/year) and some using the English system (day/month/year); this has caused issues in accuracy in some SUI reports.

- There is no consistency in the recording of medication within the SUI reports; some medications are recorded, some not and the same with any medication changes. There is no complete list of medications at the time of the incident. There are no side effect profiles recorded in the incident review reports. It is not possible to tell as part of the incident review therefore, whether medication may have been considered as a possible contributory cause.

- Credibility and validity of any review is enhanced by retaining a fidelity between those reviewing an incident and those staff involved in an incident. This distinction is not made within the existing SUI incident reports ('membership of review team' section).

- KPI performance information that supports the monitoring of clinical competence ie. staff training/appraisal information has not been considered as a possible contributory factor within the incident review process.

- There are a number of omissions within the incident reports, notably secondary diagnosis, medication at time of incident, side-effect profiling.

- There was inconsistency in the quality of the incident reports produced by the dedicated SUI investigation team.

- There was inconsistency in how staff taking part in the learning review meetings perceived the level of support and the no blame culture in the context of SUI management.

6. Action Plan Assurance/Governance

A further element of the thematic review specifically related to an independent assurance review of the action plans related to the 15 incidents.

A governance requirement within the TEWV incident review process is to ensure where lessons can be learnt relating to an incident that clear actions are identified and implemented within the organisation. There is a requirement therefore for an action plan to be developed in association with each incident.

As a result NEMHDU placed a requirement on the organisation to provide evidence for assessment to enable a determination as to whether individual actions had been completed. The evidence for each action was reviewed to determine a RAG rating, Red indicating no assurance, amber limited assurance and green full assurance.

The assurance review was undertaken on the 14th December 2016. In total 80 action points were identified across the 15 action plans. Of these 80 actions 74 had past the target completion dates. The 6 actions that had not reached the completion dates were therefore excluded from the assurance review process. The results of the assurance review are set out in the table below:

Figure 19: TEWV Thematic Review action plan assurance levels (14th December 2016)

	Full Assurance	Limited Assurance	No assurance	Total
Number	34	23	17	74
Percentage	46%	31%	23%	100%

The project team were informed that historically accountability for assurance of action plans and the collation of evidence had been held at a service level. This position represented a weakness in the corporate governance necessary for the Trust Board to be assured that where action had been identified following an incident, that action had been implemented and there was robust evidence of this being embedded in the organisation.

However, this weakness had been identified proactively by the Director of Quality Governance prior to the assurance review and positive action had been taken to mitigate this weakness. Capacity had been introduced into the patient safety team to:

- Review action plans when they were developed to ensure the actions and evidence required were credible, valid and the action plan was 'Fit for Purpose'. Only those

actions that are identified as a route cause or a contributory finding are included in the incident action plan.

- A thematic review of incidental findings on a quarterly basis (those findings having no direct impact on the incident itself) by locality management governance boards
- Ensure the accountable action plan owner and individual action leads received timely information and were clear what was required in relation to their assigned responsibilities
- Maintain a contemporaneous performance management tool to monitor and prompt owners /leads in relation to all identified actions
- Provide the executive management team with an exception report for any action that exceeded the completion date by 31 days

Whilst undertaking the assurance process a thematic analysis of the action plans identified a series of themes that are repeatedly documented within the plans. The following table represents the themes identified:

Figure 20: Action plan themes

The recent improvements to the internal assurance process had only been effective for a period of 2 months at the point of the assurance review being undertaken. This represents a very limited period to objectively evaluate the impact and effectiveness of these changes. Anecdotal information suggested the recent changes were starting to produce positive results.

NEMHDU believe actions associated with learning lessons relating to serious incidents are fundamental to the continuous improvement in developing safe and supportive services. The recent steps taken to improve the corporate governance in this area are a positive step

and there is some evidence of a very positive effect in a relatively short period of time. However, it is important to evaluate the effectiveness of these revised arrangements and ultimately this should be determined by the Trusts performance in meeting, and assuring itself it is meeting, the action targets set by its own governance process.

7. Recommendations

Recommendation 1:
In relation to the Trusts approach to clinical risk assessment and management training the Trust should ensure:

a) Compliance to the KPI training target and supportive management action to address underperformance.
b) The training to include the importance as a minimum clinical requirement of leave decisions being reviewed on the day leave commences, not only for detained but informal patients and this being clearly documented in the clinical record.
c) The Trust leave policy should be reviewed and refreshed alongside an awareness programme for ward staff.
d) Inclusion of risk assessment in the context of leave being included in the annual clinical audit plan.

Recommendation 2:
The Trust should take a proactive approach to managing risk during the first 24-hour period of leave, by:

a) Ward staff contacting the patient on leave.
b) Ensuring appropriate communication with family/carers prior to leave commencing.
c) Provision of crisis contact points.

Recommendation 3:
The Trust may wish to consider a more detailed review of the use of Bank staff and their role pertaining to leave decisions and risk assessment prior to leave in assuring itself of best practice.

Recommendation 4:
The Trust should identify the most appropriate method to cascade the learning from this report directly to those staff involved in making decisions regarding leave/absence from the ward.

Recommendation 5:

The Director of Quality Governance should:

a) Review the approach for internal SUI investigations to ensure the relevant areas identified in this report are incorporated into an updated standardised framework for use by reviewing officers.

b) Bring together reviewing officers to discuss and refine the new framework to ensure consistency, understanding and support.

Recommendation 6:

The Director of Quality Governance should, evaluate the effectiveness of the revised action plan assurance arrangements and address any remedial issues to enable assurance to be monitored and addressed to a consistently high standard.

Recommendation 7:

On an annual basis, the Trust should undertake a thematic analysis of all action plans for the preceding 12 months. The outcome of this thematic review is considered strategically within the business planning priorities of the organisation in terms of service development issues.

Appendix 1

The criteria

Ward demographic data to include:

- Type of ward/ function
- Location of ward
- Catchment population
- Number of / gender of beds
- Admissions over study period
- Discharges over study period
- Average occupancy over study period
- Workforce data (Turnover / Vacancy Factor)
- Staff satisfaction survey
- Patients satisfaction survey
- Carer satisfaction

Profile of Patient Criteria	Source
Age	Incident Report
Gender	Incident Report
Marital status	Incident Report
Previous admission(s)	Incident Report
Ethnicity	PARIS
Employment status	Incident Report
History of previous self-harm	Incident Report
Living arrangements	PARIS
Legal status	Incident Report
CPA status	Incident Report
Primary Diagnostic group[11]	Incident Report
Secondary Diagnosis	Incident Report
Risk assessed on day of leave decision (if yes specify FACE or narrative)	Incident Report
Risk assessed on day of leave commencing (if yes specify FACE or narrative)	Incident Report
Leave care plan in place (Section 17 compliant where applicable)	Incident Report
"Stop line conversation" took place	Incident Report
Pharmacological treatment	Incident Report
Side effects profile evident	Incident Report
Psychological treatments	Incident Report

[11] a) Personality Disorder b) Depression c) Bi-Polar disorder d) Anxiety Disorder e) Substance misuse f) Psychosis g) Dementia

Physical illness	Incident report
Number of days since admission prior to commencing leave episode	Incident Report
Number of leaves during current admission prior to leave episode when incident occurred	PARIS
Transfer during admission	Trust Information request
Mental capacity assessment (MCA1 form on PARIS)	PARIS
Profile of Incident Criteria	**Source**
Day of week	Incident Report
Time of day	Incident Report
Outcome death / near miss	Incident Report
Cause of death / near miss[12]	Incident Report
Profile of Ward Criteria	**Source**
Ward identifier	Incident Report
Ward Occupancy on day leave commenced	Trust Information Team
Staffing level actual (q/u)	Trust Information Team
Staffing level planned (q/u)	Trust Information Team
Admission out of normal catchment area (Y/N)	Trust Information Team
Bank staff	Trust Information Team
Ward special observations on day of incident	Trust Information Team
Medical locum use for ward	Trust Information Team
Staff appraisal position	Trust Information Team
Training position, particularly staff risk training status	Trust Information Team

(Blue = additional criteria identified at clinicians' focus group)

[12] a) Hanging/strangulation b) CO poisoning c) Jumping /Multiple Injuries d) drowning e) Self-Poisoning

Appendix 2

Data not available

- Admissions over study period
- Discharges over study period
- Average ward occupancy over study period
- Staff satisfaction survey at time of incident (data provided from latest survey which is not relevant to this review)
- Special Observation on the day of the incident
- From the SUI reports there is insufficient information on all of the cases to verifythe time of day that the incident occurs.

Appendix 3

Framework for learning review meetings

1. Ward Activity. Can you help us understand what the ward activity was like around the time of the incident?

For example, were there:

- Issue of any illicit drug problems on ward?
- were there any staffing issues at time of incident, ie. Holidays, bank staff?
- "Swing" bed issues or other specialist aspects such as military beds?
- Other patients on observations on the ward at the time?

2. Were there any information gaps in PARIS that you are aware of?

For example, was the patient:

- from a newly acquired locality?
- been transferred from elsewhere?

3. Were there any issues of communication around the incident?

For example:

- issues with outside agencies/community teams etc?
- issues communicating with family in relation to leave?

4. Is there anything you else you think was relevant that might help us do things differently in the future?

5. What impact did the person's legal status have on the level of risk assessment carried out at the time of the incident?

Learning review trigger points:

Has there been a change in legal status prior to the incident? (Focus group)

Were there high levels of temporary staffing at the time of the incident? (Focus group)

Identified from NEMHDU review team as relevant to above questions? (NEMHDU)

Grouping of incidents, eg. ward, consultant? (NEMHDU)