Review of evidence of actions taken by Sussex Partnership NHS Foundation Trust following an independent investigation into the care and treatment of Mr RS

October 2017 Final report

A review of the evidence provided by Sussex Partnership NHS Trust that the Trust had implemented the action plan arising from an independent investigation of the care and treatment of Mr RS (published October 2016)

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First published: February 2018

Version: Final report

Caring Solutions UK Ltd is a professional consultancy for mental health and learning disability services.

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Acknowledgements

We wish to thank all those who contributed information and evidence to enable us to complete this review.

Contributors include those who provided written information and those who agreed to a telephone conversation to clarify and confirm the documentation. We are particularly grateful to the Associate Director of Nursing who coordinated the provision of information and additional evidence, and facilitated telephone conversations with staff.

All parties provided invaluable information and insights which form the basis of this report.

Contents

1 Introduction

Background

1.1 NHS England (South) commissioned this assurance review of action taken by Sussex Partnership NHS Foundation Trust (the Trust) following the independent mental health homicide review of the care and treatment provided to Mr RS by the Trust.

1.2 The mental health homicide review was published in October 2016[1]. The review made five recommendations for change to the practices and policies of the Trust. In response to these recommendations the Trust produced an action plan: we have reviewed the implementation of these actions to assess the extent to which these actions have been implemented and embedded throughout the Trust.

Terms of Reference

1.3 The terms of reference for this review were provided by NHS England, as follows:

> "We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public."

Process

1.4 The Trust sent us their action plan with evidence of completion embedded. All members of the team were sent this for comment. Two members of the team met to review this in detail and identify where we felt that additional evidence, clarification and discussion would enhance our review further.

1.5 We reviewed a number of documents and data provided:

- 'The action plan based on the recommendations of our independent review of Mr RS's care and treatment' (updated August 2017).
- 'Adults – risk assessment/screening (combined) form' (electronic records, in use from 9 March 2017) – Recommendation 1.
- Data on uptake of clinical risk training - Recommendation 1.
- 'Report of an audit of clinical risk assessment and safety planning/risk management policy and procedure, Quarters 2 and 3, 2015/16' - Recommendation 1.
- 'Clinical Risk briefing for SI Mortality Group and SH Prevention Group', January 2017 - Recommendation 1.

[1] Report of the independent review of the care and treatment of Mr RS

- ‘Clinical risk assessment and safety planning/risk management policy and procedures’, ratified 7 August 2017 - Recommendation 1 and 2.
- ‘Clinical risk assessment and safety planning/risk management: Essential training 2017’ (e-learning course) - Recommendation 1and 2.
- ‘Carers and confidentiality policy’, July 2016 - Recommendation 2.
- ‘Job planning policy medical staff (non-training grade)’: December 2015 - Recommendation 3.
- Patient safety learning event (medicines incidents) poster: June 2017 - Recommendation 3.
- ‘Revalidation and medical appraisal policy’ (to be validated) - Recommendation 3.
- Making families count conference, June 2017 – agenda and evaluation – Recommendation 4.
- ‘Incidents and Serious Incidents Policy’ June 2017 – Recommendations 4 and 5.
- Family Liaison Lead leaflet - Recommendations 4 and 5.
- Root Cause Analysis training agenda - Recommendation 4 and 5.
- Examples of ‘Patient Safety matters’ for May 2017 – Recommendation 4 and 5.
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- Patient Safety Learning Events – June and August 2017 – Recommendation 5.
- Evaluation of Patient Safety Learning Event, June 2017 – Recommendation 5.
- Attendance figures for the new learning from incidents and serious incidents events, April, June and August – Recommendation 5.
- Action plan from the Thematic Review – May and August 2017 progress reports – Recommendation 5.
- Example of minutes of Thematic Review meeting – Recommendation 5.
- Thematic Review - report to the Board of Directors May 2017 – Recommendation 5.
- Annual Mortality & Serious Incidents Report - report to the Board of Directors June 2017 – Recommendation 5.
- CPA checklist plan – Recommendation 5.

1.6 Telephone conversations were held with the following Trust staff:

- Associate Director of Nursing Standards and Safety, to clarify the information sent and to discuss further information requested (on three occasions);

- Deputy Director of Social Work for an overview of the Trust's work on the Triangle of Care;

- Professional Occupational Therapy (OT) Lead (Brighton and Hove) for a discussion of their front line work with the Triangle of Care and other forms of support for families and carers.

2 Recommendations

2.1 We made the following five recommendations, arising from the findings of our review.

Recommendation 1

The Trust-wide Risk Panel develop a reliable method for systematically and comprehensively obtaining the views of family members where appropriate when screening for risk.

Recommendation 2

The Trust ensures that all staff fully understand the limits to confidentiality, particularly in relation to risk of harm to self or others, and ensure that practice is in line with legal, professional and Department of Health guidance.

Recommendation 3

The Trust ensures that all medical staff receive sufficient support from colleagues and peers who are available to them. For trainees, this should include supervision by consultants and for consultants, peer group learning. Reflective practice should be embedded into the supervision process, into continuing professional development and into organisational practice.

Recommendation 4

The Trust Board should consider signing up to the 'Triangle of Care' or similar systematic and comprehensive approach to involvement of families, significant others and carers. The objective is to support culture change to promote full engagement of carers, and to include carers as partners, along with service users and professionals, in all aspects of the appropriate delivery of care and services.

Recommendation 5

As part of its ongoing monitoring and evaluation of the implementation of the recommendations made by the internal review, the Trust should include stakeholder feedback – to answer the question: are these changes making a difference to service users, carers and staff?

3 Implementation of recommendations and action plans

3.1 In addition to the action plan arising from these recommendations, the Trust, jointly with NHS England, commissioned a thematic review of homicides by service users of the Trust, and a service user who was a victim of homicide (referred to as the thematic review). This thematic review was carried out by Caring Solutions (UK) Ltd and published in October 2016. Some of the actions

being carried out in response to the thematic review are relevant to or enhance actions taken in response to the Mr RS investigation and, where appropriate, we have referred to the thematic review actions.

3.2 Trust actions and evidence of completion for each recommendation are described below.

Recommendation 1 – We recommend that the Trust-wide Risk Panel develop a reliable method for systematically and comprehensively obtaining the views of family members where appropriate when screening for risk.

3.3 We have reviewed a clinical risk policy which includes guidance on involving family/significant others in risk assessments. This policy was ratified on 7 August 2017 and is due for review in August 2019. The policy does have a clear section on the importance of involving families and carers in carrying out risk assessments. This policy notes that families can either help protect against risk or pose a risk to the service user and that involvement of the service user, family and carers will need to be carefully considered.

3.4 Our recommendation focusses on risk screening, recommending that families should be involved in screening for risk (at initial assessment) 'where appropriate'. Following discussion, the Trust has agreed a definition of 'where appropriate' with us. The Trust has confirmed that it would be inappropriate (and impractical) to obtain the view of families in all cases when screening for risk. Screening or, if indicated, a full risk assessment is carried out at first assessment for all referrals, some of whom are not offered further treatment by the Trust. There is an expectation that families should be informed and wherever possible involved when:

- there is known risk of harm to family member(s); and
- the presentation is complex (for example, those referred to the services identified in paragraph 3.6).

3.5 Whilst it would be good practice to seek consent from the service user for the Trust to access contact details for family members, consent would not be required where there is a known current risk of harm to others.

3.6 The policy sets out when a full risk assessment (including involvement of families or the rationale for non-involvement) should take place:

"If elevated risks are evident the practitioner should proceed with completing a comprehensive risk assessment, and for some services it has been agreed that a comprehensive assessment is required at the outset (forensic services, crisis resolution home treatment teams, inpatient units, assertive outreach teams & learning disability services)."

3.7 We have reviewed the clinical risk training (e-learning) which was introduced in April 2017. This again clearly sets out the importance of involving family and carers, as well as the service user, in the assessment of clinical risk. This includes:

- "enabling shared decision making and positive engagement;
- involving service users, family and carers is key to a collaborative, strengths based and recovery approach;

- family and carers are often integral to relapse prevention, safety planning and risk management;
- carers and families can be an important source of information."

3.8 At July 2017, 2908 staff had completed their clinical risk training which represents 92% of those who need to complete the training. Since the implementation of the revised training in April 2017, 391 staff have completed this with the rolling programme in place to ensure staff complete. In addition, face-to-face training has been developed and trainers have been trained. At the end of May 2017, 139 people had attended the face-to-face training and more sessions were scheduled to be held.

3.9 The new risk assessment form was provided – this includes risk screening and comprehensive assessment in the one document: both sections include assessment of risk to others: the comprehensive risk assessment does include space for recording if family/carers have been involved in the risk assessment and for providing a reason if not. The risk screening document does not include any provision for stating who has been involved in screening for risk.

3.10 The Trust made available the audit report on their clinical risk and safety planning/risk management for quarters 2 and 3 of 2015-16. This report includes a very detailed audit of the process standards set out in the policy in place at the time. Standard 1 relates to the involvement of carers in risk assessment and a record of the reason if carers did not contribute. Compliance with this standard ranged between 81 percent and 57 percent by service. A recommendation that improvement should focus on carer involvement was made to six services. A number of services had made improvements, when information was collected in July 2017. The Trust is currently in the process of repeating this audit.

3.11 In January 2017 a briefing report provided an update to the 'Serious Incident and Self Harm Prevention' group on progress in developing the clinical risk policy, the training initiative, and strategy at care group level for workshops, reflective practice and ensuring clinical risk is included in supervision.

3.12 In conclusion, the Trust has demonstrated that it has audited compliance with the expectation to involve carers in risk assessment, or if they are not involved, to document the reason. The Trust identified areas where compliance with this standard in risk assessment had been less than acceptable and has reported that improvements were being made and recorded.

Recommendation 2 – The Trust ensures that all staff fully understand the limits to confidentiality, particularly in relation to risk of harm to self or others, and ensure that practice is in line with legal, professional and Department of Health guidance.

3.13 The Clinical Risk policy recognises mental health professionals duty of confidentiality to service users and to carers. The policy includes a clear statement that it is legitimate to breach confidentiality, without the consent of the service user, if there is a risk to others including carers or members of the public, particularly when a potential victim has been named.

3.14 The policy also notes the relevance of information governance and mental capacity when deciding whether or not to share information with family and carers.

3.15 The Trust also has a 'Carers and Confidentiality Policy' (July 2017) which also includes the guidance that listening to information provided by families and carers is not a breach of confidentiality and can be of great benefit in developing care for the service user, protecting carers and others. The policy includes the guidance that information provided by carers is confidential: staff need their consent before sharing it with the service user. The policy concludes with the statement that:

> "Even if consent to share information is withheld by the service user it is essential that we listen to the concerns of carers around clinical risk issues".

3.16 Listening to carers is a question of culture and raising awareness, not of process – therefore this policy has not been audited: we agree that this policy does not lend itself to audit. There is clear evidence from the Trust that issues of carers and confidentiality are included in training and learning events, as well as in this policy (details in paras 3.13, 3.15, 3.18).

3.17 Compliance with information governance training (covering the legalities) for clinicians and non-clinicians was 90 percent (May 2017). The Trust monitors this on an ongoing basis.

3.18 A 'Patient Safety Event' has recently (August 2017) been held on the topic of 'involving carers and confidentiality', which included a carer as one of the presenters. Thirty-two front line staff attended from in-patient and community services, along with matrons, a service director, a clinical director (medical) and an associate medical director. The latter has asked if the Trust can facilitate this event for medical staff in each of their Continuing Professional Development (CPD) sessions. A trust-wide event is planned for October 2017.

3.19 In conclusion, the Trust is clear in its policies about the issues around breaching confidentiality in line with legal constraints and about the importance of listening to carers, particularly when they have concerns which relate to clinical risk. Compliance with information governance is routinely monitored and is high. The patient safety event, co-facilitated with a carer, represents an important contribution to the Trust's implementation of this recommendation.

Recommendation 3 – The Trust ensures that all medical staff receive sufficient support from colleagues and peers who are available to them. For trainees, this should include supervision by consultants and for consultants, peer group learning. Reflective practice should be embedded into the supervision process, into continuing professional development and into organisational practice.

3.20 The Trust provided the following information in response to actions to implement this recommendation, correct at June 2017:

- Consultants attend CPD-peer groups. Attendance at the consultant CPD peer groups are not centrally recorded, however all consultants have to engage in appraisal and GMC revalidation process which is clear about requirements for CPD/peer group supervision. The Trust's policy on revalidation and appraisal, which we have seen, is compliant with General Medical Council (GMC) guidance. The policy also states that its implementation will monitored by Executive Medical Director, who will provide feedback to the Trust Board. The letter to be sent to a doctor who

do not engage with the appraisal process are very clear that the GMC will be informed if the doctor does not respond to an initial letter. Revalidation requirements apply to non-training grade doctors.

- Job planning in place supported by appropriate policy;
- Trainees are required to attend weekly Balint groups. The Principal Adult Psychotherapist facilitates two groups for the Trust, one for staff-grade psychiatrists, and the other for junior doctors and psychiatry trainees, which meet, in principle, weekly for one hour per group. The facilitator provided further information on how these groups work in practice[2]. Figures for the Brighton and Hove service indicate consistent attendance at these groups;
- Educational and clinical supervision is in place and requirements are included in consultant job plans;
- Patient Safety learning events (details in paras 3.35, 3.42, 3.43) have been recently implemented and will be included in the academic programme for trainees.

3.21 The 'Job Planning Policy Medical staff (non-training grades), ratified December 2015 includes reference to opportunities for personal and professional development to help drive quality improvement. Participation in annual job planning is a contractual requirement for Consultants and SAS (staff grade, specialty and associate specialist) doctors. The policy includes provision for including the following activities in these job plans:

- clinical supervision of trainees;
- educational supervision of trainees; and
- continuing professional development, including reflective practice and case-based discussions.

3.22 The Medical Director monitors compliance with the job planning policy quarterly, with twice yearly reports to the Board of Directors. Results are shared as appropriate to address areas where standards are not met.

3.23 Patient safety events include one in June 2017 on learning from medication incidents, which was attended by, amongst other staff, one Specialty Doctor and one Consultant. A poster which advertised this event was provided to us, as an example – posters for all these events are circulated to academic leads.

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[2] Balint groups are essentially reflective practice groups which offer GPs and Psychiatrists the opportunity to reflect on clinical cases through a psychodynamic, rather than a medical, perspective. The aim is to understand a patient's presentation in terms of their personal history and experience, and also to look at, and make sense of, the response they elicit in practitioners. The relationship with the practitioner is understood as an enactment of the patient's "reciprocal roles" or habitual relationship patterns. Group members are invited to bring cases for the consideration of the group. The content of the discussion is confidential, within the usual limits. It could include talking about the necessary practical steps to be taken if a patient is seen as a danger to him/her self or to another person. The choice of who to discuss is entirely the group members'. For further information, see: Balint Groups

Recommendation 4 – The Trust Board should consider signing up to the 'Triangle of Care'[3] or similar systematic and comprehensive approach to involvement of families, significant others and carers. The objective is to support culture change to promote full engagement of carers, and to include carers as partners, along with service users and professionals, in all aspects of the appropriate delivery of care and services.

3.24 Prior to December 2016, the Trust adopted a model of 'shadowing the ToC' – all teams across forensic and adult services were expected to carry out the ToC self-assessment. There was lots of good practice, but it was happening in pockets: the Trust has more recently committed to a more Trust-wide, strategic and systematic approach which is now being implemented. There is a Board-level project plan for the first 12 months. The Trust has recognised the need to implement ToC fully and systematically across the Trust and thereby to make a difference to carers and service users.

3.25 The Trust became a member of 'Triangle of Care' (ToC) and there is full commitment of the Board and there is a nominated Executive Lead (the Chief Nurse) for carers. The Chief Executive, along with the three main carers support organisations for mental health which operate across Sussex, signed up to this. This membership commenced from 1 August 2017.

3.26 In Brighton there is a well-established Triangle of Care group and a programme of actions developed by that group. The Trust has also appointed a Carers' Lead, themselves also a carer, who is working across the Trust to lead carer support and implementation of the ToC.

3.27 There are ToC meetings across the Trust, which are accountable to the Board. All in-patient teams are to carry out the self-assessment within this first year – ToC has become part of normal business, not an add-on. The Trust has links with the local authorities[4], and attends meetings chaired by a local authority.

3.28 Carer Awareness training (part of the ToC model) is being carried out across the Trust and is being arranged for the coming 12 months. This training is co-facilitated[5] with a carer.

3.29 As an example of local good practice, the Brighton and Hove (B&H) service has been working to develop ToC since July 2016. Within the service this is led by the Professional OT Lead, whose clinical role focusses on improving service user and carer engagement in individual care. They also lead on carer input for the Recovery College[6], with involvement in setting up co-facilitated carer skills training for the College and links with the Carer Lead.

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[3] For full details about the Triangle of Care, including the six key elements and the self-assessment tool, see: Carers included: a guide to best practice in acute mental health care

[4] Local authorites are responsible for carrying out carers' needs assessments and for funding support to carers (across all types of health and social care needs).

[5] 'co-facilitation' refers to carer(s) being equal participants with professionals in developing and delivering the training.

[6] Sussex Recovery College offers educational courses about mental health and recovery to service users, families and carers, which are designed to increase their knowledge, skills and promote self-

3.30 In mid-2016, the service began a ToC Forum. Community teams were all asked to carry out the ToC self-assessment, based on the six key principles.

3.31 The B&H service has good links with the local authority's carer services and they provide advice to carers on how to access the local authority provision. There are good links with B&H City Council carers' leads, working on a more robust carers' assessment pathway.

3.32 One of the business objectives for the B&H service focusses on service user and carer involvement in assessment, treatment and discharge. Team objectives are to improve communication with families and carers for each service user and this to be monitored in supervision. So this objective is also contained in all team and individual development plans.

3.33 ToC and carer support activities in B&H have included:

- developing a co-production model, with service users, families and carers working alongside healthcare staff, to contribute to service development;
- four community teams have piloted and three have completed ToC self-assessments, and are developing individual ToC action plans for their service;
- carer awareness training is co-produced (collaborative work involving staff, families and carers). So far in 2017, 60 staff from community teams have attended, along with another programme taken up by 50 GP trainees and junior doctors. Three further dates have been set for community teams later in 2017 and they are approaching the acute wards about providing this;
- involvement of the acute in-patient wards, developing links with ward managers and supporting the self-assessment process;
- an introductory leaflet, about specific services, written in consultation with carers;
- recording in individual care plans information about carer involvement, the service user's agreement, or otherwise, to share information with carers;
- reinforcing the message to junior doctors about circumstances in which they can share information about a service user with their family/carers, and what healthcare professionals can hear from carers;
- linking with carers who are willing to get involved with service development (as opposed to individual care and treatment);
- one service is co-facilitating with carers a mental health carers wellbeing course and carers support group;
- two events for carers and service users, which focussed on managing in time of crisis;
- involving service users and carers in recruitment of staff, sitting on interview panels;
- a poster on information sharing with carers for staff and families;

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management. The focus is on helping people to take control, becoming an expert in their own wellbeing and recovery. Source: Sussex Recovery College

- collaborative training on care planning, which is co-produced and jointly delivered;
- asking candidates at job interviews what they know about ToC and how to implement it;
- working to include a section about carers in the electronic patient recording system, with a clear process to record and review the consent to share information, carer involvement – this information will be easily accessible when staff open the record, and will enable staff can see immediately what information the service user has agreed to staff sharing with families and carers.

3.34 Overall, staff are keen on collaborative working but need help with how to make it work: the ToC approach will assist staff in developing confidence and skills in working with families and carers. Having a relationship with carers and families through the Recovery College helped the service engage with carers, and find carers who were interested in getting involved.

3.35 The Trust has developed other activities related to ToC and carer/family support.

- The 'Incidents and Serious Incidents Policy' (May 2017) which has a very clear statement that 'the needs of the family and carers affected by the serious incident must be the key focus of the Trust's investigation and response' (p. 7). The policy provides clear guidance on who is to inform families about an incident involving a relative, how they should be told and details of the role of Family Liaison Leads.
- Root Cause Analysis training includes involving families in incident investigations.
- A new system of 'Family Liaison Leads' – their role is to engage with and support families and carers through the difficult process of serious incident investigations. The aim is to ensure that families are treated appropriately, professionally, with respect and according to their diverse needs. This role is additional to the lead investigator who will work in parallel with them. Training for this role is provided by police family liaison officers and support/supervision will be made available.
- A 'making families count' event (provided jointly with NHS England), which aimed to promote the status of families in serious incident investigations and to ensure they are central to the process. The programme for the day included input from carers. This was a day conference and was very well received.
- Patient Safety Matters – a means for teams and staff to share learning from good practice as well as when things go wrong. The issue for May 2017 focussed on involving carers in the care and treatment of service users, and in investigations following a serious incident.

3.36 The thematic review also included a recommendation for the Trust to fully implement the ToC. A 'Homicide Thematic Review Group' which is chaired by the Chief Executive meets to plan and monitor progress against this recommendation; the Board is also kept informed of progress. The Chief

Executive is fully committed to leading the implementation of the ToC across the Trust.

3.37 Overall, we commend the Trust in taking forward full commitment to and implementation of the ToC at a senior and strategic level; and the work of local services in working enthusiastically to put the principles of ToC into practice, as evidenced in Brighton and Hove.

Recommendation 5 – As part of its ongoing monitoring and evaluation of the implementation of the recommendations made by the internal review, the Trust should include stakeholder feedback – to answer the question: are these changes making a difference to service users, carers and staff?

3.38 For this assurance review, the Trust informed us of relevant actions it has taken in relation to serious incidents and learning, as described in the following paragraphs.

3.39 Discussions are starting in the Trust about how action plans can influence change. The Trust is developing a 'common themes' approach to Serious Incident recommendations and action plans. They are starting to think differently, and by using the themes considering how these can be used to influence care and practice rather than simply a list of actions. This is supported by the new 'Patient Safety Matters' which focuses on a patient's story, linking to national evidence and local themes

3.40 Recently the Deputy Chief Nurse has established an internal serious incident scrutiny panel, which will look in-depth at three reviews to draw out common themes, identify the type of work the Trust needs to focus on and how to influence care and practice. They identify 'must dos' and good practice issues. Also, in the last six weeks, the Trust has asked each 'Care Delivery Service' to look at their 'open' action plans which is assisted by identifying common themes.

3.41 The Trust commits annually to a clinical audit forward plan. The Trust participates in all national audits, prescribing audits and local audits of high risk areas. This includes the National Audit of Schizophrenia, Audit of Mental Health Act Policies and Procedures and Clinical Risk. Clinical Audit reports are completed which includes service specific action plans. An example of the audit report on clinical risk has been described previously (para. 3.11).

3.42 Patient safety learning events were introduced in April 2017. These events last for three hours and are intended to appeal to front-line staff, student nurses and trainee doctors as well as other staff. The plan is to facilitate one of these events every 6-8 weeks. These are very new and will take time to embed. Topics so far have been:

- Learning from incidents (six staff attended) – nurses, a social worker and one doctor;
- Medication and safety – 16 staff attended, nurses in inpatient and community services, student nurses, service managers, psychologist and a doctor. A pharmacist helped to co-facilitate and they have been asked to repeat this for nurses in B&H for one of their development days;
- Involving families in care; and carers and confidentiality – this session was co-facilitated by a carer; 32 staff attended (details in para 3.18).

3.43 Results of the evaluation of the medication and safety event were generally positive, and all 16 staff would recommend the training to their colleagues.

3.44 A ‘Making Families Count’ event focussed on ensuring families are the focus of the Trust’s serious incident investigations (details in para 3.35) and is to be repeated; there are plans for a further event with NHS England on ‘Learning from homicides and other serious incidents, making sustainable organisational and practice changes’; and the family liaison role has been created to support families through the process of investigations (details in para 3.35).

3.45 The Board received a detailed report on the progress of implementing the actions from the thematic review in May 2017, including the progress made on learning from incidents.

3.46 In June 2017, the Board of Directors received the Annual Mortality & Serious Incidents Report, with detailed information about serious incidents occurring in the Trust during the financial year 2016/17. This report includes a numerical analysis of incidents reported, together with themes of learning drawn from the incidents and the mechanisms being developed to facilitate learning from incidents across the Trust.

3.47 The revised Incidents and Serious Incidents Policy and Procedure (2017) includes a detailed section on ‘sharing learning’ which includes:

- sharing the investigation report with the team(s) involved with the service user (to whom the incident relates);
- developing action plans based on recommendations and lessons learnt (completion of action plans will be monitored);
- sharing findings with families and carers;
- recording incidents, investigations and findings – the electronic system helps identify themes and trends;
- sharing key themes and trends through newsletters, training days and seminars;
- reports to the Safety and Quality Committees, which are then reported to the Board.

3.48 The Trust provided clear evidence that they are developing and monitoring the action plan arising from the thematic review at the highest level.

3.49 Prior to commencing this review, we had been informally advised (by a senior manager who has now left the Trust) that the Trust did not carry out ongoing monitoring of the implementation of action plans arising from internal investigations. Overall, although the Trust has not implemented Recommendation 5 as specifically written, the Trust has demonstrated its commitment to learning from incidents and is looking at ways to move towards changing practice and culture to improve safety and quality of the care and treatment it provides. The Trust has provided clear evidence of a specific focus on involving families and carers in investigating incidents and in sharing the learning with them.

4 Conclusions

4.1 We have conducted an independent assurance review of evidence of the Trust's implementation of their actions arising from our recommendations. The Trust has provided detailed supporting information.

4.2 Overall, we have been impressed by the Trust's enthusiasm and commitment to involving families, carers and service users in developing services and providing care and treatment to individuals. This is particularly demonstrated by their progress in taking forward the Triangle of Care – the work which was already being carried out by some local services is now being supported by Board-level strategic goals and a systematic, Trust-wide, approach which is underpinned by their membership of the ToC: this is actively led by the Chief Executive.

4.3 The Trust has an explicit policy which provides accurate guidance to develop a culture where professionals listen to families and carers and understand that it is not a breach of confidentiality to hear concerns. The Trust is also clear that risk of harm to the service users or to others is clear grounds for breach of confidentiality.

4.4 Likewise, the explicit expectation that professionals will involve families and carers (or record the reason(s) if not) in risk assessment of all service users whose risk is 'elevated' is welcomed. Comprehensive information will enable mental health staff to come to a valid and reliable conclusion to enhance the safe care of their service users, families and carers.

4.5 There is also clear evidence that families and carers are being invited to contribute to serious incident reviews, to learning from serious incidents and, where appropriate, to disseminating that learning.

4.6 Training for staff, using a variety of methods, in risk assessments, in learning from serious incidents and in carer and family involvement is being rolled out and is being evaluated, with positive results.

4.7 Training and support for medical staff – trainees and consultants – is in place, and meets both the requirements of education and GMC revalidation.

4.8 Two recommendations have not been fully implemented as specifically written.

i. Recommendation 1: The Trust has explained why they consider that it is not feasible to include families in risk screening for all potential service users at first contact and have set out criteria for identifying those service users where comprehensive risk assessments should be completed. We wish to emphasise that those assessing risk, at whatever stage of the process, must ensure that they have all the information they need to form a valid basis for their professional judgement of any risks.

ii. Recommendation 5: Our final recommendation was not implemented as written, but the Trust has described steps taken to improve their investigations of serious incidents, learning from these incidents and changes to practice.

4.9 Overall, we conclude that the steps taken by the Trust in response to our recommendations should help to reduce the likelihood of an event such as the

death of Mr RS's mother happening in the future. These steps should strengthen the barriers which minimise human errors in the delivery of mental health care and treatment.