Mental Health Homicides Thematic Review:

Quality Assurance Review

Volume I Main Report

September 2020

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We are extremely grateful for the help given by those who provided us with information and advice throughout the course of the investigation who unfailingly responded to our requests with good humour.

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

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1 Executive summary

1.1 Overview

1.1.1 In 2016, Sussex Partnership NHS Foundation Trust (hereafter called 'the Trust') and NHS England jointly commissioned and proactively published an independent review of homicides involving patients under the care of the Trust from 2011 – January 2016. The aim was to scrutinise the Trust's response to provide assurance to the public, patients and carers, commissioners and the Board of Directors that learning has been embedded within the organisation.

1.1.2 This Quality Assurance Review examines the impact the Thematic Homicide Review has had on patient safety, organisational governance and effective care delivery within the Trust.

1.1.3 The Trust is one of the largest mental health trusts in the country providing mental health, specialist learning disability, secure and forensic services for Brighton and Hove, East Sussex and West Sussex and specialist community child and adolescent mental health services reaching into Hampshire. The Trust operates from over 100 sites and serves a population of 2.9 million people, employing approximately 4600 staff. There are 611 mental health inpatient beds. Most of the registered locations are owned by the Trust. However, in some places, the services are provided in hospitals managed by other NHS trusts (acute hospital trusts). The Trust also provides primary medical services for HMP Lewes and HMP Ford. The Trust has two adult social care services – a care home and a domiciliary care service. In August 2018, the Trust was caring for 43,517 patients with 40,288 clinical appointments during that month. During that month there were 6,401 new referrals to the Trust.

1.1.4 Since the Thematic Homicide Review was written, the Trust has led significant changes in the culture of the organisation. They have initiated a move away from a culture which was primarily centrally-driven, target-led, and performance-managed, towards developing a nurturing, empowering culture in which 'front line' staff are encouraged to develop their own ideas for improvement and innovation, and to be responsible for their own learning and development. The aim is to create an open and honest environment.

1.1.5 The CQC is an independent organisation which regulates health and social care services. Inspectors visited the Trust unannounced from September to December 2017 to check the quality of four core services (CQC 2018a, CQC 2018b) and rated these services as 'Good'.

1.1.6 The CQC carried out a 'well-led' inspection in January/February 2019, with the report published in June 2019 which covered three services and the 'well-led' question for the Trust overall. The CQC rated the Trust overall as 'Good', while 'Are services caring?' was rated as 'Outstanding' (CQC 2019a).

1.2 Terms of reference

1.2.1 The purpose of this Quality Assurance Review is to establish whether the service-related recommendations identified in the Thematic Review have been addressed by the Trust and the relevant Clinical Commissioning Group (CCG).

1.2.2 This process will focus on identifying both quantitative and qualitative evidence that provides assurance that learning identified within the thematic review has been embedded across the organisation(s).

1.2.3 The assurance review should identify whether the Trust and CCGs' governance structures continue to provide effective reporting, monitoring and learning from serious incidents in line with the NHS England Serious Incident Framework - Supporting Learning to Prevent Recurrence[1] and subsequent policy and organisational development.

1.3 Output

1.3.1 We have presented the report in two volumes – Volume I contains the key findings and Volume II contains supplementary information to support and expand upon our key findings.

1.4 Methodology

1.4.1 In response to the Thematic Homicide Review the Trust set up a Homicide Thematic Review Group which developed a series of action plans to tackle each of the recommendations made in the Thematic. For each action the Trust set out one or more actions, the form that assurance of completion would take, a nominated lead responsible for the action and a timescale for completion. The Trust has subsequently updated the action plan and the Trust has continued to work on the recommendations even though its initial action has been completed to its satisfaction. The latest version is dated 10 July 2018.

1.4.2 We asked the Trust to provide evidence of completion of each of the recommendations. The results of this call for evidence are listed in Volume II. We then read each of the documents and evaluated them in terms of their relevance to the original recommendation.

1.4.3 We assessed the evidence of implementation using the following scheme. It is based on the three levels of compliance used in the original Thematic Homicide Review and was developed from that used by NHS Resolution with two additional categories.

1. No evidence of implementation.
2. Evidence of partial implementation.
3. Level 1 – Policy: evidence of implementation has been described and documented.

[1] NHS England (2015) Serious Incident Framework – Supporting Learning to Prevent Recurrence (see Appendix J for details).

4. Level 2 – Practice: evidence of implementation has been described, documented and is in use.
5. Level 3 – Practice: evidence of implementation has been described, documented and is working across the whole organisation(s).

1.4.4 In addition to the documentary evidence, we carried out two direct assessments of case materials. The first was a desk-top review of a sample of Level 2 (definition on p 21) Serious Incident investigation reports relating to service users who were of working age and living in the community. All of the cases with action plans were then traced through the Trust's monitoring to see if their processes complied with the Trust's own serious incident policies and procedures.

1.4.5 We also asked the Trust to provide a five per cent random sample of current cases of service users of working age and living in the community with information about those aspects of their care and treatment which had been recurrent themes in the Thematic Homicide Review. We wanted to know how far the Trust had been able to improve these aspects of patient safety.

1.4.6 We also recognised that the Trust and its environment have changed since the publication of the Thematic Homicide Review in September 2016. We interviewed the Trust officers listed as responsible for implementing individual recommendations. This not only gave us insights into the issues facing the Trust at the time of publication but also how they had responded to other changes confronting the Trust.

1.4.7 One of the aspects of wider changes in the NHS has been the growth of Quality Improvement (QI) and we noted that the Trust has now integrated some aspects of the recommendations with a QI approach. Consequently, we interviewed the Trust QI lead.

1.4.8 In total we carried out 15 semi-structured interviews. Interviewees were sent a letter in advance explaining the reasons for the interview and listing any specific discussion topics so that the interviewee could have an opportunity to refresh their memory of events. In addition to speaking to the Chief Executive, we also interviewed two Non-executive Directors and 13 current or former members of the Trust. We also interviewed a representative of the Trust's commissioners responsible for overseeing the quality of the Trust's work.

1.5 Findings

1.5.1 The Thematic Homicide Review produced eight recommendations specifically for the Trust. We have looked at how the Trust interpreted our recommendations and what steps they took to implement them. We also looked at how the commissioners are monitoring the investigation of serious incidents and implementation of their action plans.

Recommendations for the Trust

Recommendation 1

"The Board of Directors should monitor the implementation of the CDS structure and the use of the Safeguard Serious Incident recording system (Ulysses) to assure itself that investigation management and implementation of action plans are consistent with trust policies, processes and systems."

1.5.2 We concluded that the Trust had met this recommendation at Level 3 on the basis of the evidence listed below:

- The Trust's committee structure which brings details of serious incidents, their investigation and implementation of action plans to the Board of Director's attention through a variety of routes.
- The Board agendas always include a section on quality which deals with the work of other committees and groups which work on the details of serious incident investigations, incidents and near misses.
- At each Board meeting the Chief Executive (CEO) includes a discussion of serious incidents in her report.
- There is also a structure of meetings at Care Delivery Service (CDS) level, which again considers serious incidents, their investigation and implementation of action plans.
- The Deputy Chief Nurse, the Service Director and the Clinical Director for the CDS are responsible for ensuring that learning from incidents is shared across the Trust.
- The membership of the Trust's committees shows that the Trust requires senior staff to attend lower-tier committee and panel meetings so they have access to the granular detail of serious incidents and consequently have detailed knowledge of the Trust's daily work.
- The Trust Board receives an Integrated Performance Report at each meeting which includes information on topics including the completion of risk assessments and Care Programme Approach (CPA) reviews as well as staffing levels. The Trust has set up a process of standardising the format of reporting by each CDS to enable comparisons to be made across the Trust.
- We carried a desk-top study of all the Trust's Level 2 investigations completed in 2018 on patients of working age living in the community. We concluded that the Trust's processes for investigating serious incidents and embedding learning were robust and, on the whole, timely.

1.5.3 We had two concerns which persisted even though a great deal of work has been done since the Thematic Homicide Review:

- There is a tension between the Trust's goals in its Clinical Strategy to allow local variations to reflect local needs and its ability to assure itself that lessons are embedded across the Trust.
- We found that the recommendations made in our sample of 2018 serious incident investigation reports were similar to those found in the Thematic

Homicide Review and that these issues also are known to the Trust through its own auditing data.

Recommendation 2

"The Board of Directors should build upon the work already in place to assure themselves, their stakeholders and the wider public that learning from all recommendations is being fully embedded across the organisation in a timely manner. Currently and in the future, where there is Level 1 evidence, the Board should be expecting the Trust to move towards Level 2 compliance with recommendations; and likewise, where there is Level 2 evidence the expectation of Level 3 evidence should be made clear. If these are not appropriate, then the Trust should be transparent as to the reasons."

1.5.4 We concluded that this recommendation had been achieved at Level 3 and based our judgement of the following evidence:

- The Trust has made significant changes in its approach since the Thematic Homicide Review. It consulted widely to create its new clinical strategy document published in November 2017. The Trust engaged with service users and carers asking them to define what the outcome of the clinical strategy should look like from their perspectives.
- The Trust has changed its governance structure to put service users and carers in positions of greater influence than previously.
- The Trust has revised its policy on serious incidents so that families and carers are now involved in the investigation process (to the extent that they wish) from the initial stages to sharing the final drafts of serious incident reports with the family/carers.
- The Trust has changed the way it communicates safety messages across the organisation.
- In September 2018, the Trust held a 'Learning form Serious Incidents' conference which attracted over 250 people from a variety of professional roles across the Trust.
- The Trust and the NHS England South Mental Health Homicides Team developed a one-day training event on 'Learning from when things go wrong' in November 2017.
- In June 2017, the NHS England South Mental Health Homicides Team facilitated a development session for the Trust on 'Making Families Count' with an emphasis on best practice initiatives and protocols for involving families in investigations when incidents occur.
- The Trust provided face-to-face clinical risk assessment training where Trust trainers and service users facilitate team events. A Lead Clinician for Risk Assessment Training was appointed in September 2018 and training has been provided for over 660 staff to date.
- During 2019, the Trust has been running a series of 'Supporting Safer Inpatient Services' workshops for nurses and health care assistants (HCAs) as the principal target audience.
- In March 2109, the Trust launched 'Safewards' an initiative designed to reduce conflict and containment on psychiatric wards.

- The Trust routinely uses 'safety huddles' on wards and they have access to the incident dashboard which allows them to compare their experiences with those of other teams.
- The Clinical Governance Team collects data on those who attend training/learning events. Attendance information is loaded onto the MyLearning system which allows local managers to monitor staff compliance with mandatory and other training. Local managers use this information as part of clinical supervision and to manage staff availability on wards or in teams.
- The Trust Board receives the Integrated Performance Report at each meeting with a dashboard of overall Trust performance as well as data on quality indicators by CDS. The Trust's target for risk assessments is 95% while actual performance was 85% in April 2019. Since 2017, risk assessment compliance has shown little variation around 82.9% which is significantly below target. The range among the community CDSs is between 70.35 and 81.4%. The target for CPA reviews is also 95% but actual performance is 79.4% and the performance of community CDSs ranges from 63.1% to 96.2%.
- The Trust has recently begun a number of QI initiatives to tackle these less tractable patterns of performance and local plans are being made to address the underlying problems.

1.5.5 The Trust should monitor the reports of the Working Together Groups and the Positive Experience Committee to assure itself that service users and carers do not experience unplanned variations between CDSs. Service users and carers find local variations within a single Trust confusing and frustrating.

Recommendation 3

"The Board of Directors should assure themselves that there are robust systems in place to provide evidence that actions have been implemented in a timely manner and in line with the requirements of each action plan."

1.5.6 We concluded that this recommendation had been achieved at Level 3 and based our judgement on the following evidence:

- In addition to the committees, boards and panels which review serious incidents from an operational perspective there is also a 'governance' structure. This includes a number of committees which check that serious incidents are graded accurately, ensures the consistency, transparency and quality of investigations, and monitors implementation of action plans
- The Quality Committee receives a Serious Incident Assurance Report at each meeting which includes the statistics seen by lower-tier meetings but also a table describing each serious incident.
- The Trust commissioned an independent consultancy (RSM) to carry out an audit of the implementation of serious incident action plans which traced through the various processes and tested the reality against the Trust's model.

- The CQC has also investigated the Trust's serious incident processes in cases of unexpected deaths and reported that the investigation reports were thorough and the investigation process could identify root causes.
- At the time of writing, the Clinical Governance Team has been reviewing the serious incident policy in anticipation of the publication of the new national framework for investigating serious incidents. The Team is working on outcome measures to assess the impact of changes following from their identification of recurring themes in investigations.

Recommendation 4

"The Trust should ensure that clinical staff have dedicated time for recording notes and record-keeping; that staff record the rationale for the clinical decisions they make and use risk assessment and formulation to inform relapse planning."

1.5.7 We concluded that this recommendation had been achieved at Level 2 and based our judgement on the following evidence:

- The Trust has made modifications to Carenotes (the electronic patient record system) to standardise and improve the quality of information recorded. Staff are supported to improve record-keeping through clinical supervision.
- The Trust has moved from a reliance on e-learning to more face-to-face learning through the appointment of a Clinical Lead for Clinical Risk and in excess of 660 staff have attended since September 2018. The training is being evaluated and staff say it is very relevant to their jobs, has improved their confidence in improving patient safety and they have learned from the training.
- The Trust has carried a number of clinical audits by applying nine clinical risk and six care planning standards to samples of service user records. Overall compliance with the quality standards for risk assessment and care planning for community service users was 78%. The auditors did, however, find considerable variation between wards and teams and across topics within wards and teams. Community teams were found to be 'low' on measures of service user/carer involvement.
- A standard risk assessment letter is now sent to GPs by psychiatrists after clinics.
- The Trust has been working on a number of ways of protecting time for clinical administration including record keeping. Some changes in job planning have allowed the Trust to build in administration time but this applies to only a limited number of posts.
- The Trust has struggled to implement protected time due to the pressure of workloads but it has looked at ways of supporting staff locally. Some teams have been able to come to agreements between themselves on ways to protect administration time.
- The Trust is trying to reduce the time taken to keep records by reducing the amount of material to be recorded and by the use of 'single capture' reports. Some letters can now be composed from material collected for assessments.

- Our analysis of a five per cent sample of current adult age cases of people living in the community (120 cases) found that comprehensive risk assessments had been completed in all 'high risk or complex' cases and in nearly all 'low risk or not complex' cases. The same levels of completion were found for risk management, but record keeping for crisis/contingency planning was less complete and there was some evidence that carers and families were not being involved as frequently as they should have been.
- Care plans and clinical interventions were personalised for both risk groups and there was evidence that planned interventions had been carried out.
- We did, however, find differences in completion rates between the CDSs but the number of cases was too small to allow comparison by risk levels within the CDSs.
- We would encourage the Trust to continue their work in raising the levels and standards of completion of clinical records through the use of local management dashboards and through Quality Improvement projects.

Recommendation 5

"The Trust should investigate the feasibility of technological solutions to make it easier to complete records and improve productivity. This might include the use of voice recognition technology when recording on the electronic record system."

1.5.8 We concluded that this recommendation had been achieved at Level 3 and based our judgement on the following evidence:

- The Trust made voice to text technology (Dragon Dictate) widely available across the Trust and has provided training for anyone who wishes to use it. Some 507 staff were registered to use the system in January 2019.
- The Trust has surveyed staff on their use of the system and has used comments to solve the practical problems thrown up by the survey.
- Those staff who have persevered with Dragon Dictate and whose jobs fit best with its use have found that they can save up to five hours a week and reduce the turn around time of clinic letters from two weeks to one.
- In the process of introducing Dragon Dictate the Trust has learned valuable lessons.
- The Trust has also used alternative approaches to improving record-keeping 'on the move' through the provision of laptop computers with 4G mobile data devices.

Recommendation 6

"The Trust should consider developing a checklist of key requirements, based on the themes identified in this report, to be used in all CPA reviews."

1.5.9 We concluded that this recommendation had been achieved at Level 3 and based our judgement on the following evidence:

- In May 2019, the Trust's Care Planning Quality Improvement Group began to investigate how to produce a simple, user-friendly checklist that could be used at CPA review meetings but the service user and carer

representatives argued strongly that this should not be part of the Carenotes system but should be sent to each service user as part of the invitation to attend the review.

- The Trust held three engagement events to improve care plans and commissioned independent facilitators to access service users, carers and staff in a creative way so they could be asked 'what should a good care plan look like?'.
- As a result of these events, the Trust held training events to explore the idea of co-produced[2] Personal Support Plans. The training was well-received by those involved, and PSPs have been developed.
- The Trust has devised quality standards for PSPs.
- In March 2018, audit data showed that just over 50% of all adult service users had a valid PSP compared with 40% 12 months earlier. Completion rates were higher in community CDSs than the adult service average overall. There were some variations between the adult CDSs.
- In January 2019, the Trust set up a working group to review internal and external evidence and best practice for care planning with the aim of developing a single co-produced care plan for every service user across the Trust. One care plan will be used from the point of entry and will include all acute and community care received from the Trust.
- In our own five per cent sample of current cases we found that a PSP had been completed in every case irrespective of risk or complexity of the case, or CDS.

Recommendation 7

"When the Trust evaluates training and education, they should evaluate not only the learner experience but also the impact of the training, using a model such as Kirkpatrick:

Level 1: Reaction (Staff enjoyed and engaged in the training)
Level 2: Learning (Staff acquired the intended knowledge, skills and commitment from the training)
Level 3: Behaviour (Staff apply what they learned back in the workplace)
Level 4: Results (Achievement of organisational targets or goals as a result of the training)."

1.5.10 We concluded that this recommendation had been achieved at Level 3 and based our judgement on the following evidence:

- Since the Thematic Homicide Review the Trust has led on significant changes in the culture of the organisation away from being centrally driven, target-led and performance-managed. There has been movement towards a nurturing, empowering culture in which front-line staff are encouraged to own ideas for improvement and innovation and to be responsible for their own development and learning. This empowering culture permeates the QI, Organisational Development (OD) and Team Development Day (TDD) activities with training included in these activities rather than being an end

[2] 'Co-production' refers to service users and/or carers working on an equal basis with professionals to produce an output.

in itself. We have, therefore, evaluated the evidence in light of this move towards culture change rather than the letter of the recommendation.

- The Trust has not used the Kirkpatrick model (or similar) but has used a number of alternative approaches aiming for similar outcomes.
- The Trust has evaluated its clinical risk e-learning package against Levels 1 and 2 of Kirkpatrick.
- To ensure that their training is purposeful, the Trust has mapped its mandatory training courses on to the Skills for Health core skills framework. The annual training plan is aligned with clinical strategy.
- The Trust is promoting additional methods for improving patient safety, including TDDs, OD and QI programmes. These incorporate training but do not rely on 'stand-alone' training for effecting change.
- However, the annual training plan makes no reference to 'value for money', impact on practice or organisational objectives, or to evaluation of the training being provided.
- Evaluation forms ask attendees for a view on the training's relevance to their work, and to increasing their confidence that patient safety will be improved and asks about the usefulness of the sessions.
- The Trust intends to embed the impact of training through clinical supervision and appraisal.
- Data presented by the Trust shows how much supervision is recorded but at present it is impossible to discover the proportion of staff who have received supervision.
- The Trust operates a computerised system for MyLearning which manages training and education: staff log training, supervision and appraisal and consequently managers can monitor their staffs' training and education activities.
- The Trust has a Preceptorship programme for newly-qualified or newly-appointed nurses of 14 study days over 12 months. Serious incidents are used as course material.
- The Trust has a system of Clinical Academic Groups which design the different care pathways. These Groups also provide feedback on the impact of new interventions after staff have attended training.
- The Trust is committed to implementing effective and meaningful involvement of service users and carers in understanding the impact of their experience of services.
- The Trust has provided evidence of training affecting staff and service user behaviour, and the influence of evidence on policy-making. Further training has supported the introduction of revised policies.

1.5.11 The Trust collects evaluative materials following each training event and actively makes improvements in future events based on the evaluations. Although the Trust has not followed the recommendation to the letter, they have developed more comprehensive means to improve care and treatment, and the evaluations they have carried out do demonstrate they are providing the conditions (attendance, relevance, confidence and learning) for quality improvement and for improving patient safety.

Recommendation 8

"The Trust should continue to act on its commitment to implementing the 'Triangle of Care' approach to involving carers in the care and treatment of service users. The Trust should aim to achieve membership of the national programme within 12 months."

1.5.12 We concluded that this recommendation had been achieved at Level 3 and based our judgement on the following evidence:

- The Trust very quickly embraced the philosophy and practice of Triangle of Care (TOC) and was accepted as a member in August 2017. The Trust submitted their self-assessment for stage one in September 2018. An external review panel awarded accreditation status for stage one in July 2019.
- The CEO and Trust Board are committed to ToC being part of the fabric of delivering recovery-oriented care. The Trust is putting ToC at the centre of its organisational strategy, placing family and friend carers alongside service users and staff.
- The Trust is working to submit self-assessment for all 200 community teams by the end of 2019.
- The Trust has developed a number of approaches to implementing ToC – these include the appointment of a Trust-wide Carer Leader; establishment of a ToC Advisory Group; carer awareness training across the Trust; and carer support leaders who have been appointed at two hospitals and in the forensic healthcare service.
- Carers report being supportive of the Trust in ways which did not occur in the period before the Thematic Homicide Review and referrals by Trust staff to carer support agencies have increased significantly in some areas covered by the Trust.
- The Trust has provided a range of evidence on supporting and involving families following serious incidents and in serious incident investigations. The Trust takes its Duty of Candour seriously and complies in the vast majority of cases, exceptions being when no next of kin is known to the Trust.

1.5.13 The Trust has made significant progress in involving family and friend carers and we support the Trust in its planned further developments.

Quality Improvement in the Trust

1.5.14 Although Quality Improvement was not mentioned in the original recommendations in the Thematic Homicide Review it has clearly become an important element in the Trust's approach to improvement and is, therefore, included in this review.

1.5.15 The Trust's QI programme has been running since 2017 and work has been going on to build the Trust's capacity. The programme is Trust funded with CQC support and focuses on co-produced services. At the time of this review, some 473 staff had completed QI Bronze level training. There are also 286 staff

from across the Trust including the Board who had achieved the Silver level accreditation. The Training is experiential so it is accessible regardless of academic background.

1.5.16 The projects are self-determined – people work in areas of high value to themselves and their team. A project begins with a workshop which assesses the service at it sees itself. The QI team then work out their priority areas and develop a project feeding into local service priorities. Examples of these projects include work on supervision standards and risk assessment.

1.5.17 In addition, the Trust has introduced Excellence Reporting as part of its online incident reporting system. Examples reported recently include 'going the extra mile' and examples of episodes of care that worked well. The Trust is contributing to regional and national mental health safety collaboratives, and has launched an internal safety collaborative.

Review of Clinical Commissioning Groups' monitoring of serious incident action plans

1.5.18 The Terms of Reference for this quality assurance review includes the following:

"The assurance review should identify whether the Trust and CCGs governance structures continue to provide effective reporting, monitoring and learning from serious incidents in line with the NHS England Serious Incident Framework – Supporting Learning to Prevent Recurrence and subsequent policy and organisational development."

1.5.19 There have been significant changes in the configuration of CCGs in Sussex since the Thematic Homicide Review was published in 2016. We did not receive information from the CCG which was responsible for monitoring the Trust's compliance with our recommendations so cannot review this. However, we have been provided with information on how the current arrangements work and have held discussions with the Head of Quality at Brighton and Hove CCG who is currently the lead for reporting and monitoring learning from serious incidents at the Trust.

1.5.20 The current 'Policy and Procedure for Reporting and Managing Incidents and Serious Incidents' (October 2018) sets out the processes and procedures for reporting and managing all incidents and serious incidents, including near misses. The policy applies to all incidents, serious incidents and near misses that involve patients, carers, visitors, staff, premises, property, other assets or data in commissioned services. The policy highlights the need for an open and transparent approach which maximises learning and avoids blame or staff feeling under threat through incident reporting and investigation.

1.5.21 In summary, this policy sets out the responsibilities of the CCGs to report, monitor and agree to the closure of incident investigations and to gain assurance that action plans are being implemented. The mechanisms and processes the CCGs use are described in detail in paras 11.7 to 11.21.

1.5.22 We reviewed notes of meetings of the CCG's Sussex Partnership NHS FT Clinical Quality and Performance Group (SPFT CQPG) for February, March and for April 2019 which clearly demonstrated that the CQPG was carrying out detailed and rigorous monitoring of incidents, serious incidents and near misses. We also reviewed two serious incident reports to the CCG's Quality and Safety Committee which again demonstrated a robust focus on requiring evidence that lessons learnt and action plans are embedded in practice. We noted that the CCGs and providers are required to engage with patients and carers to identify where quality improvements are needed and to inform the commissioning process.

1.5.23 Overall, we felt that the tone of the meetings demonstrated a culture where commissioners and the Trust were working collaboratively to improve quality and safety in response to serious incidents. This includes clear evidence of effective monitoring by the CCG of serious incident investigations and action plans. Their policy and practice are compliant with the requirements of NHS England (2015).

2 Overview

2.1 In 2016, Sussex Partnership NHS Foundation Trust (hereafter called 'the Trust') and NHS England jointly commissioned and proactively published an independent review of homicides involving patients under the care of the Trust from 2011 – January 2016. The aim was to scrutinise the Trust's response to a range of incidents to provide assurance to the public, patients and carers, commissioners and the Board of Directors that learning has been embedded within the organisation.

2.2 This Quality Assurance Review examines the impact the Thematic Homicide Review has had on patient safety, organisational governance and effective care delivery within the Trust.

2.3 The Trust is one of the largest mental health trusts in the country providing mental health, specialist learning disability, secure and forensic services for Brighton and Hove, East Sussex and West Sussex and specialist community child and adolescent mental health services reaching into Hampshire. The Trust operates from over 100 sites including the community service and serves a population of 2.9 million people, employing approximately 4600 staff. There are 611 mental health inpatient beds. Most of the registered locations are owned by the Trust. However, in some places, the services are provided in hospitals managed by other NHS trusts (acute hospital trusts). The areas covered by the Trust are in line with local government social services areas of Brighton and Hove, East Sussex, West Sussex and Hampshire. The Trust also provides primary medical services for HMP Lewes and HMP Ford. The Trust has two adult social care services – a care home and a domiciliary care service. In August 2018, the Trust was caring for 43,517 patients with 40,288 clinical appointments during that month. During that month there were 6,401 new referrals to the Trust.

2.4 Since the Thematic Homicide Review was written, the Trust has led significant changes in the culture of the organisation. They have initiated a move away from a culture which was primarily centrally-driven, target-led, and performance-managed. We were provided with examples which tended to be characterised by staff feeling disempowered and disengaged, low staff morale, poor staff retention and high sickness levels. The move is towards developing a nurturing, empowering culture in which 'front line' staff are encouraged to develop their own ideas for improvement and innovation, and to be responsible for their own learning and development. This enables staff to be empowered and able to lead change, using untapped potential at ward and team level. The aim is to create an open and honest environment.

2.5 The CQC is an independent organisation which regulates health and social care services. A team of inspectors visited the Trust unannounced from

September to December 2017 to check the quality of four core services[3] (CQC, 2018a, CQC, 2018b). These services were at that time rated as 'Good'[4].

2.6 The CQC carried out a 'well-led' inspection in January/February 2019, with the report published in June 2019 (CQC 2019a). The inspection covered three services[5] and the 'well-led' question for the Trust overall. The CQC again concluded with an overall rating of 'Good' for the Trust, with the individual questions rated as follows:

- Are services safe? Good
- Are services effective? Good
- Are services caring? Outstanding
- Are services responsive? Good
- Are services well-led? Good

2.7 The CQC's Deputy Chief Inspector of Hospitals (and lead for mental health), Dr Paul Lelliott, said that he was delighted that the Trust had taken to heart the comments made in the previous report and had acted to bring about improvement. He said that during this inspection the CQC had found examples of good practice in all core services they had inspected. They saw a significant improvement in the quality of care. Services were more flexible and highly personalised to meet patients' individual needs (Dr Paul Lelliott, 2019).

3 Executive sponsors

3.1 The executive sponsors of the project were: the Chief Nurse and the Chief Medical Officer of the Trust; and the Head of Investigations NHS England (South).

4 Terms of reference

4.1 The purpose of this Quality Assurance Review is to establish whether the service-related recommendations identified in the thematic review have been addressed by the Trust and the relevant Clinical Commissioning Group.

4.2 This process will focus on identifying both quantitative and qualitative evidence that provides assurance that learning identified within the thematic review has been embedded across the organisation(s).

4.3 The assurance review should identify whether the Trust and CCGs' governance structures continue to provide effective reporting, monitoring and learning from serious incidents in line with the NHS England Serious Incident Framework –

[3] The four services inspected were: acute wards for adults of working age and psychiatric intensive care units; wards for older people with mental health problems; community-based mental health services for adults of working age, and specialist community mental health services for children and young people.
[4] The previous inspection in 2016 rated the Trust as 'Requires Improvement'. (CQC 2016)
[5] The three services inspected were: mental health crisis and health-based places of safety; forensic inpatient/secure wards; and wards for older people with mental health problems.

Supporting Learning to Prevent Recurrence and subsequent policy and organisational development.

5 Further learning

5.1 The Quality Assurance Review Team (see Appendix A for details) will assist in co-producing any further action plans with the Trust and relevant CCG.

5.2 The Quality Assurance Review Team will provide a range of feedback and learning opportunities for staff and service users across the relevant organisations.

6 Governance

6.1 The Quality Assurance Review will be managed through the Corporate Governance systems of NHS England, Sussex Partnership Trust and the relevant CCG.

7 Outputs

7.1 A report that establishes whether learning from the thematic review has been implemented and embedded and identifies any gaps in that learning, and steps that are being taken to address those gaps.

7.2 A report identifying any service-related themes/wider issues or links that are apparent from the thematic review.

7.3 A report that identifies any good practice or areas for development in relation to Trust and CCGs quality assurance framework.

7.4 Where the review team identify additional recommendations and actions which fall outside of the thematic review, these will be highlighted directly to the relevant organisation, i.e. NHSE, Clinical Commissioning Group or Trust.

7.5 We have presented the report in two volumes – Volume I contains the key findings and Volume II contains supplementary information to support and expand upon our key findings.

7.6 A report that is suitable for publication on NHS England's and the Trust's websites.

8 Methodology

8.1 In response to the Thematic Homicide Review the Trust set up a Homicide Thematic Review Group which developed a series of action plans to tackle each of the recommendations made in the Thematic. For each action the Trust set out one or more actions, the form that assurance of completion would take, a nominated lead responsible for the action and a timescale for completion. The Trust has subsequently updated the action plan and the Trust has

continued to work on the recommendations even though its initial action has been completed to its satisfaction. The latest version is dated 10 July 2018.

8.2 In the light of the Trust's approach to the Thematic Homicide Review we asked the Trust to provide evidence of completion of each of the recommendations. The results of this call for evidence are listed in Volume II. We then read each of the documents and evaluated them in terms of their relevance to the original recommendation. Several elaborations of the recommendations are wider in scope than we had intended in the original recommendations.

8.3 One of the criticisms of the Thematic Homicide Review approach is that the recommendations could have been improved by more detailed discussion with the Trust about the underlying intentions of the recommendations.

8.4 We assessed the evidence of implementation plans using the following scheme. It is based on the three levels of compliance used in the original Thematic Homicide Review and was developed from that used by NHS Resolution (formerly the NHS Litigation Authority) with two additional categories.

1. No evidence of implementation.
2. Evidence of partial implementation.
3. Level 1 – Policy: evidence of implementation has been described and documented.
4. Level 2 – Practice: evidence of implementation has been described, documented and is in use.
5. Level 3 – Practice: evidence of implementation has been described, documented and is working across the whole organisation(s).

8.5 In addition to the documentary evidence, we also carried out two direct assessments of case materials. The first was a desk-top review of a sample of Level 2 Serious Incidents investigation reports relating to service users who were of working age and living in the community (see Appendix E for details)[6]. All of the cases with action plans were then traced through the Trust's monitoring to see if their processes complied with the Trust's serious incident policies and procedures.

8.6 We also asked the Trust to provide a five per cent random sample of current cases of service users of working age and living in the community with information about

- comprehensive risk assessment
- risk management
- crisis/contingency planning
- review of risk
- care planning/intervention.

[6] For a detailed description of the three levels of investigation – concise internal investigation (Level 1), comprehensive internal investigation (Level 2) and independent investigation (Level 3) see NHS England (2015) page 42.

8.7 We were particularly concerned about these areas of treatment and care in the Thematic Homicide Review and wanted to know how far the Trust had been able to improve these aspects of patient safety.

8.8 The documents provided by the Trust provided a considerable amount of information on which to form a judgement about the Trust's success in implementing the recommendations but we also recognised that the Trust and its environment have changed since the publication of the Thematic Homicide Review in September 2016. We decided that we should interview the Trust officers listed as responsible for implementing individual recommendations. This not only gave us insights into the issues facing the Trust at the time of publication but also how they had responded to other changes confronting the Trust. Some of the named responsible staff are no longer with the Trust so we interviewed the current post holders. One of the aspects of wider changes in the NHS has been the growth of Quality Improvement (QI) and we noted that the Trust has now integrated some aspects of the recommendations with a QI approach. Consequently, we interviewed the Trust QI lead.

8.9 In total we carried out 15 semi-structured interviews where we took notes and the interviewees were given the opportunity to check and amend the note of the session. The interviewees were sent a letter in advance of the session explaining the reasons for the interview and setting out any specific topics that we wished to discuss so that the interviewee could have an opportunity to refresh their memory of events. In addition to speaking to the Chief Executive, we interviewed:

- two Non-executive Directors
- Chief Medical Officer
- Chief Nurse
- Chief Operating Officer
- Associate Director of People Participation
- Director of Transformation – Operational Services
- former CPA Lead for Trust
- former Director of Training and Education
- Associate Director of Training and Education
- Head of Digital Development
- Head of IT
- Trust-wide Carer Lead
- Associate Director – Quality Improvement and Development
- Senior Nurse, Quality Improvement and Development
- Head of Quality and Nursing – Brighton and Hove Clinical Commissioning Group.

9 Recommendations for the Trust

The Thematic Homicide Review produced eight recommendations for the Trust, three recommendations for the Trust's commissioners and five for NHS England when they are commissioning homicide investigations. In this section of the report, we have looked at how the Trust interpreted our recommendations and what steps

they took to implement them, their QI programme, and how the commissioners are monitoring the investigation of serious incidents and implementation of their action plans.

9.1 Recommendation 1

"The Board of Directors should monitor the implementation of the CDS structure and the use of the Safeguard Serious Incident recording system (Ulysses) to assure itself that investigation management and implementation of action plans are consistent with Trust policies, processes and systems."

Background to this recommendation

9.1.1 This recommendation was made in the Thematic Homicide Review because we found that three-quarters of the recommendations made in the original action plans had been implemented. In one-third of recommendations the Trust demonstrated through the audit and re-audit of practice that learning was being embedded across the organisation.

9.1.2 In relation to incidents, the Board Assurance Framework report for January 2016 noted 'variable reporting of incidents in CDSs' as a 'gap in assurance'. The minutes of discussion of this agenda item are brief, but one action was agreed, namely, to develop a strategy of evidence-based pathways to go to the May meeting of the Board.

9.1.3 In January 2016, the Trust-wide Dashboard reported on the percentage of serious incident investigations which were completed and submitted within the required 60 days. Only 48% of reviews were completed on time and this organisational risk was rated 'red'.

9.1.4 We also knew about and commented on the Trust's changes in its general organisational approach – away from a centralised command and control model to one of greater local flexibility to enable local services to develop according to local needs and to have ownership of service and care delivery improvements. We believed that this might make it more difficult for the Trust's Board of Directors to be sure that learning was embedded trust-wide. The Trust has moved further in this direction subsequently and the aim is for service lines to operate as separate business units through devolved leadership where clinicians and managers can plan their services' activities, set objectives and targets, monitor their services' financial and operational activity and manage quality and financial performance. The latest CQC inspection report (CQC, 2019b) states that the Trust operates from over 100 sites including the community services and serves a population of 1.6 million people in Sussex and 1.3 million in Hampshire. The Trust employs approximately 4,617 staff through 430 teams (though some internal documents mention approximately 270 teams).

The Trust's approach to the recommendation

9.1.5 The Trust dealt with this recommendation in five ways:

a) Review each CDS against the 2016/17 annual plan with specific attention to governance
b) Fundamental standards self-assessment
c) Management of the risk register
d) Complaints – themes and performance
e) Serious incident reporting and learning (timeliness and completed actions).

The Trust's Board of Directors

9.1.6 The Board of Directors (hereafter called the Trust Board) is at the apex of the two sets of interconnected committee structures which bring to the Board's attention details of the serious incident investigation process. The two routes are described in Appendices G, K and L both in the commentary and in the tables of membership of the committees and panels.

9.1.7 The Trust Board's agendas are always divided into six major sections:

- introduction
- strategy
- quality
- finance
- governance, and
- any other business.

9.1.8 In the course of a year's meetings the Trust Board will consider approximately 30 papers from the Quality Committee. The topics covered are:

- Quality Committee Report – every meeting
- Quality Committee Report Annual Report – once annually
- Learning from Deaths report – three times annually
- Guardian of Safe Working Hours report – once annually
- Safeguarding report – once annually
- Integrated Performance Report – twice annually
- Safe Staffing report – twice annually
- Medical Revalidation and Appraisal Annual Report – once annually
- Emergency Preparedness Resilience and Response – statement of compliance – once annually
- CDS Quality assurance – twice annually
- Quality Improvement and Assurance Report – twice annually
- Eliminating Mixed Sex Accommodation Annual Update and Declaration – once annually
- Freedom to Speak Up – once annually
- Complaints Annual Report – once annually.

9.1.9 This demonstrates that the Trust Board considers information about these issues from a variety of sources and in a variety of formats.

9.1.10 The Trust Board recently considered a report from the Quality Committee reviewing the Quality Committee's annual cycle of business to ensure its work plan covers all key areas associated with the quality and safety of services. The membership of the Committee, its Terms of Reference and the sub-committees below it and their work are also under review. The Trust's intention is to ensure robust identification, prioritisation and management of any risks arising from clinical care. This is the second time the Board has reviewed the terms of reference etc for the Quality Committee since the publication of the Thematic Homicide Review.

9.1.11 The agendas for Board meetings always include a section on quality as one of the standing items for reporting and discussion. In addition, the Chief Executive (CEO) always includes a reference to serious incidents in her Report to the Board. The CEO's Report also includes a reference to the Executive Assurance Committee which discusses a Serious Incident Assurance Report at each meeting. The CEO also summarises a report of the Quality Committee meeting.

The Trust's clinical strategy

9.1.12 The Trust undertook an extensive programme of consultation to produce its 'Clinical Strategy - the next steps in our journey 2017-2020' published in November 2017. The Strategy is described as being

> 'OUR clinical strategy as 'every service user and carer lead, staff member, commissioner and partner organisation has a responsibility to see through its implementation'.

9.1.13 Delivery of the strategy

> 'will also be underpinned by the adoption of a new set of Trust-wide Quality Improvement tools and methodologies that will ensure that all change programmes are patient centred, measurable and effective in producing the changes we want to see'.

9.1.14 A key change was the introduction of CDSs which were to strengthen local leadership with clinical engagement. The Trust's eight (previously seven) CDSs have the task of providing overarching leadership for a particular care group and/or geographical area. The eight CDSs are:

- Forensic Healthcare
- Primary Care and Wellbeing
- Carehome Plus
- West Sussex (North West Sussex and Coastal)
- Children and Young People's Service and Learning Disability
- Brighton and Hove
- East Sussex
- Children and Young Person's services

- Learning Disability and Neuro-Behavioural Services.

9.1.15 Each CDS is led by a service director and a clinical director with a multi-disciplinary team (including clinical professions and back-office services) to provide additional leadership and governance oversight.

9.1.16 The Trust had no intention of creating completely independent services where the quality of care and treatment might vary but rather to provide services that 'can flex to local needs'. The Trust Board recognised that providing consistently high-quality services depended, among other things, on embedding the learning from what they do well and where they need to improve across all their services.

9.1.17 The CDS model helped the Trust to improve services for patients and carers. However, the intention was never to create completely independent services where decisions about the service offer and standards could develop in isolation.

The Trust's assurance processes

9.1.18 The Trust has two sets of bodies which exist in part at least to check on the implementation of the recommendations and action plans generated by serious incident investigations. This section of the Quality Assurance Review refers to the 'operational' side of the process while the 'governance' part is discussed in Recommendation 3 below.

9.1.19 Every month, each CDS prepares a quality assurance report. These reports include charts and a dashboard prepared by the clinical care intelligence team.

9.1.20 These CDS quality assurance reports are reviewed by a CDS Quality Assurance Panel which includes the Chief Operating Officer (COO), the Director of Performance, the Senior Finance Manager and the Head of HR/Business Partnering. This panel checks that the appropriate level of assurance is provided, reviewing areas of positive performance and acting as a means of communicating issues to other support services where required. The COO formally writes to the CDS after the review meeting to provide feedback (positive feedback, to ask for further assurance, or to acknowledge where further support is requested by the CDS).

9.1.21 Each quarter, each CDS attends its CDS Quarterly Assurance Meeting. This is the opportunity to review the quality and performance of services, the financial situation and progress in meeting the annual objectives of the CDS in detail. The meeting is attended by the COO, the Performance Director and/or the CEO and Chief Nurse as well as various support service representatives including Finance and HR. Information from both these bodies is used to produce the assurance report for the Executive Management Committee (EMC) and the Trust Board.

9.1.22 When recommendations are made in a serious incident investigation, the CDS responsible will develop and implement an action plan based on the lessons identified by the report's author and in the recommendations made.

Any action plan with Trust-wide recommendations will be shared with the Deputy Chief Nurse and managed through the appropriate Trust-wide forum of committees.

9.1.23 Completion of the action plan for each serious incident investigation is monitored by the responsible CDS with completion reported and evidenced on the Ulysses system. The general manager has responsibility for closing completed actions on the risk register which is accessed through the Ulysses system.

9.1.24 The Deputy Chief Nurse, the Service Director and the Clinical Director for the relevant CDS are responsible for ensuring that learning from incidents is shared with the staff of all grades across the Trust

9.1.25 The Operations Management Board (OMB) meets monthly and receives reports from each of the eight CDS boards as well as from the CDS Quality Assurance Panel and the CDS Quality Assurance Meeting. The CDS Quality Assurance Meeting reports to the OMB which is chaired by the Deputy Chief Operating Officer and discusses any open actions from serious incident recommendations. The OMB receives a list of Open Serious Incident Action Plans which covers:

- the themes of Open Actions for example, communication or clinical policy development
- individual action plans are colour coded Red, Amber or Green (RAG) in terms of the priority accorded to each recommendation, the action required and a statement of progress, a target date for completion and progress to date
- each action owner is identified together with details of the incident and the report's author.

9.1.26 The Trust's EMC receives a Serious Incident Assurance Report at each of its meetings. Additionally, the EMC can also receive overview papers on the serious incidents reported in the previous month and brings together the learning from all incidents, including serious incidents, and highlights recurring themes. The overviews also outline the Trust's performance in relation to the completion of serious incident investigations within the appropriate deadlines with summaries of the completed investigation reports submitted to the commissioners during the month. The aim of the report is to provide assurance to the Trust Board that the root causes have been identified and lessons learned.

9.1.27 In addition to our review of the Trust's committee structure we have looked in some detail at the membership of the various committees and groups as we believe that membership is as important as the existence of the committees (see Appendix L for details). We believe this to be the case because it would be easy for the Trust to organise committee membership on a hierarchical basis with more junior staff attending lower level (but important meetings) while 'protecting' senior staff time for bodies that are higher in the structure. By having senior staff as members of the lower tiers, the Trust communicates the

importance it attaches to the work of the committees and it means that senior staff are familiar with the details of the Trust's work.

Integrated performance report

9.1.28 The Integrated Performance Report is one of the key documents used within the Trust to assess its performance across a range of topics, for example, completion of risk assessments, staffing levels, percentage of clients in employment. The Trust has been moving to standardise the format of reporting by each CDS and the Trust also intends to standardise the 'remedial action plan' for all services to enable comparisons to be made across the Trust.

Follow-up study of serious incident investigations

9.1.29 In order to investigate the Trust's aim to have a robust serious incidents investigation process, we asked the Trust to provide us with all the Level 2 investigations they had completed in 2018 on patients who were of working age and living in the community. We planned to look in-depth at the investigations and then to track any recommendations and action plans through the Trust's processes to see how quickly and how completely any recommendations were put into effect.

9.1.30 Initially, we received 38 sets of Level 2 serious incident investigations but rejected two as they related to people who were living in care homes run by the Trust and so did not meet our criteria for inclusion. The remaining 36 cases were made up of 13 female and 22 male service users and one case which was so highly anonymised it was impossible to discover the service user's gender.

9.1.31 The demographic characteristics of the sample are set out in the table below, this way of displaying the information is adapted from the National Confidential Inquiry into Suicide and Patient Safety.

Table 1 Characteristics of patients whose deaths were the subject of serious incident reports

Demographic features	Female (n= 13)	Male (n=22)
Age: median (range)	52 (28-65)	45 (18-62)
Aged under 25	0	**
Not currently married	11	17
Living alone	8	8
Physical health problems	7	11
Clinical features		
Primary diagnosis:		
Schizophrenia and other delusional disorders	**	5
Affective disorders	9	15
Alcohol dependence/misuse	0	**
Drug dependence/misuse	0	0
Personality disorder	**	**
Eating disorders	**	**
Any secondary diagnosis	8	13
First contact with mental health services		
<12 months	5	8
>5 years	6	9
Behavioural features		
History of self-harm	7	8
History of violence	**	7
History of alcohol misuse	**	11
History of drug misuse	**	14
History of self-neglect	7	9

Note: ** fewer than 5 cases

9.1.32 The numbers involved here are too small for any statistical analysis and these figures are provided to give an overview of the cases. A discussion is provided in Appendix E together with material on their contacts with mental health services.

9.1.33 In the Thematic Homicide Review, we used a typology of recommendations devised by Niche to classify the recommendations made in homicide investigations (Niche 2015). They categorised recommendations into eight common areas and we have followed that model again. Not every serious incident investigation report found care and service delivery problems that needed to be addressed in the future. There were five cases which had no recommendation and 30 cases where recommendations were made. For

examples of the issues covered by each of these recommendations see Appendix E.

Table 2 Ranking of recommendations made in Trust's serious incident reports and the Thematic Review of Homicides

Topic of recommendation	**Rank order of recommendations made in reports subject to the Thematic Review of Homicides**	**Rank order of recommendations found in current SI reviews**
Practice/Risk	1	1
Policy Management	2	2
Communications	3	3
Pathway Development	4	4
Training	5	6
Organizational (sic) Learning	6	7
Contact with families	7	8
Miscellaneous	8	5

9.1.34 It seemed inappropriate given the number of cases involved in the Thematic Homicide Review and the way they came to our attention that we should compare the simple number of recommendations made in the Thematic Homicide Review (48 recommendations made in 11 cases) compared with the number found in our survey of a sample of contemporary serious incident reports (85 recommendations made in 31 cases). A more appropriate way of looking at the information is to rank the recommendations in order of frequency of occurrence of topics.

9.1.35 The ordering of the first four topics is the same in both samples: 'practice/risk', 'policy management', 'communications' and 'pathway development'. The primacy of 'practice/risk' as a recurring issue reflects what the Trust reports regularly in the Integrated Performance Reports which are presented to every Trust Board meeting.

9.1.36 This sample of serious incident reports was also examined in terms of possible breaches of Trust and/or national policies/guidelines and it would appear that these policies had not been followed in 24 of the 36 cases though none were found to be a root cause of the incident.

Table 3 Time taken to complete the serious incident investigation report from the date of the incident to date of signature by the report's author.

Working days to complete report	**Number**
0 to 60 days	22
61 to 90 days	11
90 to 120 days	3
TOTAL	**36**

9.1.37 Twenty-two of the 36 cases had an investigation report signed by the author within the 60 working day target with 11 completed within a further 30 working days. All of the cases in this sample had been completed within 120 working days. The range was from 30 days to 108 days.

9.1.38 When there were delays in completing actions the Open Serious Incident Reports circulated within the Trust contain explanatory notes on the reason for the delay. An inspection of the Open Serious Incident reports shows that some cases (not in our sample) can drag on for some considerable time and it is not always easy for someone outside the Trust to understand all the reasons.

Conclusions

9.1.39 The Trust has built upon its pre-2016 committee and board structure to strengthen its monitoring of the completion and subsequent implementation of action plans derived from serious incident investigations. It has a number of tiers of oversight covering the serious incident process from beginning to end. The various committees and boards have interlocking membership which means that detailed knowledge of serious incidents is not restricted to less senior members of staff. Senior members of staff are involved from the very earliest stages of the process. The Chief Nurse plays a particularly important role as the focus of a number of strands of responsibility for investigating, scrutinising and implementing serious incident investigations and action plans.

9.1.40 Since January 2019, the Clinical Governance Team has implemented a revised system for monitoring the completion of action plans. This includes reviewing the evidence which enabled the closure of the action, the quality of the evidence supporting the completion and revisiting the service six-12 months later to ensure that the changes have been embedded into practice.

Recommendation 1: Implemented at Level 3

9.2 Recommendation 2

"The Board of Directors should build upon the work already in place to assure themselves, their stakeholders and the wider public that learning from all recommendations is being fully embedded across the organisation in a timely manner. Currently and in the future, where there is Level 1 evidence, the Board should be expecting the Trust to move towards Level 2 compliance with recommendations; and likewise, where there is Level 2 evidence the expectation of Level 3 evidence should be made clear. If these are not appropriate, then the Trust should be transparent as to the reasons."

Background to this recommendation

9.2.1 When we asked for evidence during the preparation of the Thematic Homicide Review that the recommendations and action plans in the original homicide investigations had been acted upon, the Trust had some difficulties in providing

supporting evidence which could demonstrate implementation. We were concerned that the Trust's administrative systems were not fully fit for the purpose of demonstrating learning from homicides and other serious incidents. In the light of this experience we were told that the Trust had introduced new methods for linking evidence with action plans electronically.

The Trust's approach to the recommendation

9.2.2 The Trust approached this recommendation in five ways:

a) Undertake a full review of the Serious Incident policy ensuring we raise the profile and scrutiny of the learning and service/practice improvement as a direct result of the lessons learned.
b) Develop local and Trust-wide learning lessons forums, focussed serious incident reflective groups, creating conditions that embed learning into practice.
c) Introduce podcasts, easy to read bulletins to ensure learning occurs at every level across the Trust.
d) The NHS England South Mental Health Homicides Team will work with Sussex Partnership NHS Foundation Trust colleagues to develop and deliver a one-day training event for clinicians entitled "Learning from homicides and other serious incidents, making sustainable organisational and practice changes". We will seek to engage our colleagues in NHS Improvement (NHSI) and the local Academic Health Sciences Network (AHSN) to maximise local expertise and contributions in line with Institute for Healthcare Improvement (IHI) methodology and patient safety best practice.
e) The NHS England South Mental Health Homicides Team will facilitate a further development session for Sussex Partnership NHS Foundation Trust delivered by the "Making Families Count" Collaborative. This session will build on the success of the summer workshop hosted by the Trust and will focus on the development of best practice initiatives and protocols in positively involving families in investigations when incidents occur.

Changes in the Trust's governance and policies

9.2.3 In November 2017, the Trust published 'Clinical Strategy – the next steps in our journey 2017-2020'. The strategy was developed in partnership with patients, carers, staff, commissioners and other key stakeholders to address the concerns and ambitions of each stakeholder group more directly. The Trust states that it has obtained consistent feedback from service users and carers about what they would like from the Trust's services. They engaged with a specific group of service users and carers asking them to define what the outcome of the clinical strategy should look like from their perspective.

9.2.4 The Trust changed its governance structure so that service users and carers would be in positions of greater influence than previously. For example, the Positive Experience Delivery Board would have a family member as a member or as the chair while the Well-Led Delivery Board would be co-chaired by a patient or carer.

9.2.5 The Trust's revised 'Incidents, Serious Incidents and Learning from Deaths Policy and Procedure' was ratified in May 2017. The policy stresses not only the importance of learning from incidents of all degrees of seriousness, but it also emphasises the development of a 'just culture of trust and respect' in which openness, transparency and learning are valued, encouraged and supported. The policy states that the needs of family and carers must be the key focus of the Trust's investigation and response. At the start of each root cause analysis (RCA), family/carers will routinely be asked if they want to be involved in the review and the Trust will establish the level and type of involvement the families want, who will link with them, the questions they would like to be asked and how they want the outcome of the investigation to be fed back to them. All final drafts of the serious incident report are shared with the family/carers for further comments to be discussed and where appropriate agreed.

Communicating safety messages

9.2.6 The Chief Nurse undertook a full review of the 'Serious Incident' policy ensuring the Trust raised the profile and scrutiny of the learning and service/practice improvement as a direct result of the lessons learned. This review was completed by April 2017. The Trust has used a variety of means of communicating messages about patient safety across its workforce.

9.2.7 The Trust organised a series of 'Patient Safety Learning Events'. The first on medication safety was attended by 16 frontline staff; a second session was facilitated by a carer and was attended by more staff. The feedback was very positive with a request for it to be repeated with the doctors in the East Sussex CDS. Later in 2018, the programme included events on 'Clinical Risk', 'Risk Assessment and Involving Carers', and 'Safeguarding Adults and Children'.

9.2.8 In 2019, the Patient Safety Learning Events programme included 'Learning from Serious Incidents and Mortality Reviews' and a specialised event for one community office on local 'Serious Incidents'.

9.2.9 The Patient Safety Learning Events are evaluated by attendees using standard evaluation forms. The form requires information on each attendee's job title and workplace so the Trust can establish the spread of staff attending from across the Trust. The form has a section on 'Training Value' which asks for attendees' views on the relevance of the training to their job. It is very rare for attendees to rate event relevance as less than either 'very relevant' or 'relevant'. Attendees are also asked for their view on their degree of confidence that this training will help the attendee to improve patient safety. Again most attendees stated that they were either 'very confident' or 'confident' that this training event would help to improve patient safety. Improvements in staff confidence in respect of tasks may be an important step towards changes in practice (see also para 9.7.43).

9.2.10 The Trust publishes 'Patient Safety Matters' to spread the learning across the Trust from the Patient Safety Learning Events beyond event attendees. It is published every four to six weeks and it goes out to all staff, clinical and non-clinical, and is available in public areas in Trust buildings. The March 2018

issue – 'Involving Families in Care' – begins with a case study where the serious incident investigation found that the service user's family was rarely involved in patient care and their views were not sought in relation to risk. This was particularly important as the service user found it very difficult to talk about themself and their risks. The bulletin reviews external policy documents on the importance of involving carers and the refusal to use patient confidentiality as a reason for not listening to families' concerns. It also provides data from some of the Trust's serious incident investigations and the family/carer involvement as an issue. There are also examples of what staff can do in their practice.

9.2.11 The Trust produces a print run of 2,000 copies of 'Patient Safety Matters' for each issue. Recent issues have covered topics including 'Safeguarding Children', 'Working with people with a diagnosis of personality disorder', 'Falls', and 'Driving Vehicle Licensing Agency and Clinical Care'.

9.2.12 The Trust produced a 'Briefing for Staff' following the publication of the Niche Level 3[7] investigation report. More recently, the Trust produced a confidential briefing for community staff on an alleged homicide and alleged attempted homicide involving service users known to the Trust. This briefing sets out several immediate learning points and the implications for practice from each of the incidents as they were then understood – before further serious incident investigations had been carried out.

9.2.13 At a more technical level, the Trust publishes a 'Clinical Message of the Month', recent examples have covered diabetes, clozapine, and sepsis. These single-page publications set out key messages on the topic of the month, for example, the issue on diabetes stresses the importance of monitoring service users' physical health, it explains what diabetes is, sets out the NICE recommended target blood glucose levels, and what to do if glucose levels are outside the recommended range. There is also a link to Diabetes UK.

9.2.14 In September 2018, the Trust held a 'Learning from Serious Incidents' Conference which was attended by over 250 people working in a variety of professional roles across the Trust. About 70 participants completed an evaluation form and most of the evaluations were very positive. The sessions on involving carers and the support for teams after a serious incident were particularly well received.

Conferences and training

9.2.15 The Trust and NHS England South Mental Health Homicides Team developed a one-day training event for clinicians entitled 'Learning from when things go wrong' in November 2017. The Trust engaged contributors from NHSI (as it then was) and the local AHSN to maximise local expertise in line with the IHI methodology and patient safety best practice. The learning event was targeted on key staff with responsibilities for shaping policy, practice and culture. Some 140 people attended.

[7] Independent review into the care and treatment of a service user who had committed a homicide

9.2.16 The NHS England South Mental Health Homicides Team also facilitated a development session for the Trust entitled 'Making Families Count' which focused on the development of best practice initiatives and protocols in positively involving families in investigations when incidents occur. The event took place in June 2017. The event included partner organisations, clinical staff and support services, carers' organisations, and commissioners' quality leads. Targets were set for each CDS for front line staff to attend. The 100 attendees were asked to consider how this event and its related learning would change their practice and to report back. Trust policies on the 'Duty of Candour' and the 'Duty of Candour Policy on a Page' have been amended to ensure that families are now more actively involved in serious incident investigations.

9.2.17 The evaluation of this event was completed by 30 attendees; respondents were asked what had they been given that would improve their awareness/understanding of the need to involve families in investigations better; whether they could see opportunities to help families participate more fully in reviews and how that leads to more effective processes; and whether they had come away with useful tools and ideas of how to include families in investigations in a better way. The great majority of respondents either 'agreed' or 'agreed strongly' with these questions.

9.2.18 In October 2018, the Trust organised presentations on 'What is Safety Culture' and a 'Just Culture' by Professor Suzette Woodward (National Clinical Director of the 'Sign up to Safety' culture change team at the Department of Health and Social Care).

9.2.19 The Trust has a Preceptorship programme for its newly-qualified and newly-appointed nurses – a programme of 14 study days in their first year of work. The programme includes 'working in partnership with service users and family, friends and carers', and material on the Triangle of Care. The programme for 2020 makes very explicit the content on serious incidents, and the Thematic Homicide Review is included in the reading materials for Day 5 (see also para 9.7.22).

9.2.20 The Trust used Health Education England (HEE) money to provide face-to-face training across clinical services where Trust trainers and service users facilitate team training events. The Lead Clinician for Risk Assessment Training was appointed in September 2018. The Lead works with teams, trainers and service users to support the programme which began in October. At the time of writing, 660 clinical staff from a wide range of settings across the Trust had attended for face-to-face training. This training has been consistently evaluated positively by attendees and uses learning from serious incidents pertinent to each locality. Some bespoke clinical risk training has been developed and delivered. The next step was to be the development of Clinical Risk Training for qualified staff to begin in January 2019. The post has been funded for another year and funding is currently being agreed to make this a permanent post. A full programme of activities is planned up to September 2019 (see also paras 9.4.6 and 9.7.42).

9.2.21 In the course of 2019, the Trust has been providing a series of 'Supporting Safer Inpatient Services' workshops. Five one-day sessions were completed in

2018 and some 70 staff attended. Nurses and HCAs were the principal groups of attendees and the Trust is looking at ways of linking similar sessions for other occupational groups of staff. These workshops concentrated on the recurring themes of learning from serious incidents and from the recommendations made in the CQC report 'Sexual Safety on Mental Health Wards' (CQC 2018a). The workshops link practical clinical skills, knowledge and learning from incidents.

9.2.22 In March 2019, the Trust held a launch event for Safewards, an initiative designed to reduce conflict and containment on psychiatric wards[8]. Fourteen wards signed up to implementing the interventions and they were encouraged to focus on two of these in the initial stage. All are at different places in the process. A follow-up conference is to be held during February 2020. Two wards have included their interventions as part of the Trust's work for a national QI collaborative around reducing the use of restrictive interventions. A Lead Preventing and Managing Violence and Aggression (PMVA) Tutor will take up post in September 2019 and they will be taking the Lead for Safewards to support wards' 'implementation of interventions, overcoming challenges and the celebration of good practice'. This member of staff will also include the Safewards model in the PMVA training they provide.

9.2.23 The Trust routinely uses team 'safety huddles' in inpatient settings which allow teams to look at their incidents and compare them with other similar teams. These are based on the incident dashboard which provides a user-friendly approach to shared learning. 'Safety huddles' are a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards.

9.2.24 When the Clinical Governance Team leads training/learning events it collects data on attendees including job title. The Learning and Development Team also collects information about those attending events and when attendance has been confirmed this is uploaded onto MyLearning. Team leaders/ward managers can produce electronically a team report on the training completed by their staff. Encouragement to attend additional training or to keep up to date with mandatory training will come from both the manager and through clinical supervision. Managers also monitor their teams'/wards' training attendances in terms of the teams'/wards' need for staff availability. Training/learning events are held in each CDS area as the Trust covers a considerable geographical area.

Monitoring the CDSs' performance

9.2.25 The Trust has a very active system for monitoring the performance of the different CDSs. The Board receives a number of performance reports at every meeting as described elsewhere (Recommendation 1 above). The Integrated Performance Report provides a dashboard of Trust performance before providing data on a series of quality indicators by CDS as well as Trust-wide. The Trust target for risk assessments is 95% while the actual performance in

[8] For more details on the model see Safewards

April 2019 was 85%. Since April 2017, risk assessment compliance has been showing little variation around an average of 82.9% which is significantly below the target. A number of underlying issues have been identified including high medical caseloads, the process of recording the risk assessment and the problems inherent in introducing a new risk assessment form in late 2018. Among the community-based CDSs, the completion rate in February to April 2019 varied between 70.3% and 81.4%.

9.2.26 The target for CPA review in 12 months is also 95%. Actual performance is significantly under target at 79.4%. A new CPA report form was published in March 2019 using a revised methodology to identify more accurately service users on CPA. Performance dropped by three per cent as an increased number of patients are now being correctly reported as being on CPA. The Trust's performance was, however, above both the national and regional figures reported in the Mental Health Services Data Set. The community CDSs reported compliance figures of between 63.1% and 96.2%.

Improving performance

9.2.27 The Trust has set up Quality Improvement projects on the level of completion of assessments and work is also being done to ensure that when tasks are carried out they are then recorded in the appropriate section of Carenotes CPA reviews. It is known that while some patients have a risk assessment on GP letters sent out after clinics this information is not being transferred appropriately to the risk assessment form. Local action plans are in place in other CDSs to address the problem of completing CPA plans.

9.2.28 The Trust has the ambition for caseloads to be 25 for community CDSs as caseload size is also thought to affect the completion and recording of risk assessment and management, crisis and contingency planning and care planning. Some teams are already doing this and they have a good, standardised approach to caseload numbers. This is the model for the Trust to move to. But other teams have struggled to get their caseloads down to 35. The aim is to prioritise those patients who need their services and ensure that those not prioritised are safe and supported. This approach is now being shared by other teams and its transferability is being investigated.

9.2.29 One CDS now covers all adult services and there is a Lead for each pathway: acute, community and urgent care.

9.2.30 The Trust should monitor the reports of the Working Together Groups and the Positive Experience Committee to assure itself that the service users and carers do not experience more variation between the CDSs than the Trust intends by its policy of allowing local variations between CDSs, and that service users and their carers do not find local variations within the Trust confusing.

Conclusions

9.2.31 The Trust has very clearly invested a considerable amount of resources in a comprehensive programme of events and activities to embed learning from the

Thematic Homicide Review across its workforce. The range of topics covered is extensive, and the approaches taken in spreading these important messages are imaginative. Evaluations have been carried out, and the Trust collects data on the diffusion of training across the organisation. The Trust uses this information at a local level to ensure that learning has been embedded across the organisation as a whole. However, performance data routinely shows persistent variations between the CDSs which cannot be accounted for by differences in recording practices alone. The Board needs to assure itself that systems are in place that clinical supervision is used to help staff integrate their learning into their daily practice and that improvements in performance follow.

Recommendation 2: Implemented at Level 3

9.3 Recommendation 3

"The Board of Directors should assure themselves that there are robust systems in place to provide evidence that actions have been implemented in a timely manner and in line with the requirements of each action plan."

Background to the recommendation

9.3.1 The rationale for this recommendation was that the Thematic Homicide Review had identified evidence that the Trust did not carry out ongoing monitoring of the implementation of action plans arising from internal investigations. It also emerged that the Trust had not implemented a recommendation, as specifically written, made in a Level 3 Independent Investigation[9]. More recently it has been reported that two recommendations made in a Level 2 investigation were not explicitly referenced in the action plan although there was evidence within the monitoring report that one of the recommendations had been addressed[10].

The Trust's approach to the recommendation

9.3.2 The Trust has addressed this recommendation through two actions:

a) Each CDS is to provide confirmation on the completion of actions arising from serious incidents by the prescribed date, and
b) Peer audit (to include service users, carer representatives, clinical staff and commissioners) to confirm that reported actions have been taken and that changes to practice are evidenced.

The Trust's assurance processes

9.3.3 At the same time as the operational meetings described above in Recommendation 1 are taking place, there are also meetings which can be seen as more to do with the governance structure of the Trust.

[9] Review of evidence of actions taken by Sussex Partnership NHS Foundation Trust following an independent investgation into the care and treatment of Mr RS (Caring Solutions (UK) Ltd, 2017)
[10] An independent investigation into the care and treatment of a mental health service user Mr W in Sussex (Niche 2018)

9.3.4 Serious Incident Review Meetings occur weekly and are chaired jointly by the Chief Nurse and the Chief Medical Officer. The Meetings are presented with a spreadsheet of the week's serious incidents and initial management reviews. The main functions include reviewing the level of investigation to ensure that it is proportionate to the incident and its potential learning; to decide if the investigation requires a panel review or an external view or review is required; to contribute, in some incidents, to the terms of reference of the review; to identify or be aware of any immediate actions that have not already been identified through the initial management review; and to consider any further support or guidance for the staff or team involved.

9.3.5 The Serious Incident Scrutiny Committee, chaired monthly by the CEO, functions to ensure the consistency, transparency and quality of investigations of unexpected deaths and serious incident root cause analyses. Up to three significant serious incident reports are presented at each meeting, minutes are taken and an action log is put in place and this is revisited at every meeting.

9.3.6 If the serious incident is a high-profile case, a clinical member of the Scrutiny Committee will attend the CDS to provide support and to establish if any immediate learning is required. A confidential internal briefing is written to share any immediate learning with similar services across the Trust

9.3.7 In Quarter 2 of 2018/19, there were five Serious Incident Scrutiny Group Meetings where 41 serious incident reports were presented and of these two incidents were downgraded and 34 were closed or conditionally closed. No independent investigations were commissioned during the quarter.

9.3.8 The monthly meeting of the Serious Incident and Mortality Review Assurance Workshop is a place for all senior staff who grade serious incidents and mortality reviews to meet and review the grading of incidents to ensure consistency of their decision-making.

9.3.9 The Safety Committee meets bi-monthly and is jointly chaired by the Deputy Chief Nurse and the Associate Medical Director. Carers attend the meetings where serious incidents are reported and since July 2018 a service user has also attended these meetings. The Committee receives a quarterly Quality and Patient Safety report on Patient Safety Incidents including serious incidents. The Committee is presented with a wide variety of information including the number of open and closed action plans and the number of overdue action plans by CDS. There is also information about the themes of action plans submitted to the commissioners in the preceding year as well as information on any Trust-wide changes to practice or on actions taken as a result of serious incidents. Any learning activities are also reported. This report also includes details of any Prevention of Future Deaths notices issued by HM Coroner.

9.3.10 The Committee also receives occasional thematic reviews of serious incidents. For example, in March 2019 it received a report on serious incidents in the community where ‘Active Engagement or Did Not Attend’ (referred to below as DNA) was noted as either ‘a lesson learned’ or as a ‘care and service delivery problem’. This was a problem in 16 out of 49 recent serious incident cases. The report put DNA in the context of evidence from research and other

findings on the risk posed by such behaviour to service users' safety. The paper concluded with a list of recommendations and implications for practice which will be taken forward in the next Trust review of its DNA policy and there will be a Trust-wide audit of DNA in the 2019/20 clinical audit cycle.

9.3.11 The Quality Committee was reformed in 2017 and it meets bi-monthly for 2½ hours. As can be seen from the chart in Appendix K, the Committee receives papers from four workstreams – the Safety Committee, the Patient Experience Committee, the Mental Health Act Committee and the Effective Practice Committee. These Committees were set up to be the places where discussion and action could take place. The sub-committees escalate and/or note issues that are required to be raised through summary reports and a Quality Committee summary is then produced to update the Trust Board.

9.3.12 The Committee does not restrict itself simply to receiving reports from below. In the course of meetings in 2018/19, the Quality Committee noted several points in the Integrated Performance Reports it receives.

- There had been a lack of improvement in several Key Performance Indicators (KPIs), for example, risk assessments, care planning, physical health assessments (which was significantly lower in some parts of adult services than others) and CPA reviews. Performance on these KPIs had plateaued over recent months. Each CDS was reviewing their action plans and their planned trajectory to achieve the indicator.
- When the panel looked in detail at the themes of serious incident reports and discussed the importance of care planning, risk assessment and service user engagement problems, the Committee said that the Trust had recently appointed a senior nurse to deliver risk assessment and care planning training across the Trust.
- The Clinical Intelligence Team has been developing the format of the report to support the Trust Board to make better use of data and analytics to understand quality and performance issues and to focus their decision making.

9.3.13 More generally, two questions remain.

- The statistics presented to the Board on the timeliness of completion of action plans concentrate on the completion of reports but they do not report how long it takes for the overdue cases to be completed i.e. the range of time taken.
- There is also the question of which body has a complete overview of the situation with serious incidents as the Safety Committee has material on the number, level of investigations, the timeliness or otherwise of completion of serious incident reports. Also it has information on the themes of serious incident action plans submitted to commissioners over time. The Quality Committee has information on serious incident themes.

The pivotal role of the Quality Committee

9.3.14 The Quality Committee which can be seen as the apex of the Trust's system of reassurance on the safety of care and treatment has had its terms of reference revised twice since 2017. One of its most significant features is that it is the first point at which Non-executive Directors have any part in the quality assurance processes. This is not to detract in any way from the diligence of the Trust staff who are responsible for the earlier stages in these processes.

9.3.15 The Quality Committee has several possible limitations.

- Its large workload with four sub-committees feeding materials to it and each of these sub-committees covers a wider range of issues.
- The membership of the Quality Committee includes three Non-executive Directors. In the period June to September 2018, there was a sole Non-executive Director who was also chair whilst two vacancies were recruited to and these posts have now been filled.
- There has been limited time for discussion – meetings were two-hours and have now changed to 2½ hours.

9.3.16 On the other hand, the Quality Committee has several strengths which include:

- Interlocking committee membership below Board level, so that senior members of the Trust see the granular detail of serious incidents and understand the detail behind the more abstract reports which are sent on to the Trust Board.
- The Quality Committee receives a Serious Incident Assurance Report at each meeting which includes the statistical materials seen by lower-tier meetings but also includes a table describing each of the serious incidents reported on the Strategic Executive Information System (STEIS) during the preceding month. A description of the incident is provided for each case so that members of the Committee can see the nature of the incidents being investigated.

External scrutiny of the Trust's systems

9.3.17 In addition to the Trust's internal processes to check on the production and implementation of serious incident investigation reports and action plans, the Board also commissioned an independent audit of the implementation of serious incident action plans from an external consultancy company, as an advisory review (RSM 2018). This piece of work traced cases through the various processes and tested the reality against the Trust's 'model'.

9.3.18 Overall, the RSM report was positive in relation to:

- the systems and processes for recording and monitoring the outcomes of serious incident investigations
- the Incidents and Serious Incidents Policy and Procedures
- the monthly Serious Incident Assurance Reports to the Board of Directors

- the support for and involvement of service users and family and friend carers (further detail in relation to Recommendation 8).

9.3.19 In addition, 20 cases were followed through the system, with only three identified where action plans had not been appropriately recorded as being completed within the designated timescale.

9.3.20 The report from RSM commented favourably on the use of the 'Patient Safety Matters' publication to convey the 'messages' from the serious incident reports to members of staff in an open and transparent way. Some 2,000 copies of each issue are printed, and they are made available throughout the Trust estate including areas which are open to the public. Service users and carers also have access to these publications. The information is also conveyed to staff via the intranet.

9.3.21 In addition to the Trust closing serious incident action plans they also have to be signed off as closed by the Commissioners (described in more detail in Section 10 of this report).

9.3.22 The Trust has also provided us with evidence of the involvement of service users and carers in teams of clinical staff and commissioners to carry out Quality and Safety Reviews of services. We have seen evidence that the comments of the peer auditors are recorded in such a way that their contributions can be identified rather than being subsumed into the final report. This approach seems to encourage service users to bring out issues which may appear minor to staff assessors but which can improve the experience of other service users.

9.3.23 The CQC reviewed samples of serious incident investigation reports where people using the service had died unexpectedly[11]. They reported that the investigation reports were thorough and clearly set out the steps taken to investigate the incident and identify root causes, with a focus on looking for improvements to prevent any recurrence, rather than apportion blame, which links in with the Trust's drive towards a more 'just culture'. There was evidence of involving families and carers, and a single point of contact for them, though their involvement in setting the terms of reference for each investigation was not always clear.

Current review of the Trust's serious incident policy

9.3.24 At the time of writing, the Clinical Governance Team, led by the Deputy Chief Nurse, are in the process of reviewing the Trust's serious incident policy in anticipation of the publication of the new national framework for investigating serious incidents. The review group is actively considering how to include outcome measures within the Trust's serious incident assurance work. For example, if risk assessments are a recurring theme in serious incident investigation reports and changes in training or a new policy are put in place,

[11] CQC Evidence Appendix. Date of inspection visit: 20 January to 28 February 2019. 2019b

the Trust wants to be able to assess the impact of such developments. This is the focus of their work for the coming six months.

Conclusions

9.3.26 We conclude from the internal and external evidence presented to us that the Trust has met this reommendation. We have seen evidence that the Trust has established a series of committees and groups which provide oversight of the serious incident process. The grading of incidents is checked and all those involved in grading decisions meet to review the way this process works. The investigations themselves are kept under a rigorous control system to check the timeliness of production of reports and the implementation of reports is kept under review. We would suggest that more work is done to support the Quality Committee which is central to the Trust Board's assurance processes.

Recommendation 3: Implemented at Level 3

9.4 Recommendation 4

"The Trust should ensure that clinical staff have dedicated time for recording notes and record-keeping; that staff record the rationale for the clinical decisions they make and use risk assessment and formulation to inform relapse planning."

Background to the recommendation

9.4.1 The rationale for this recommendation was the finding in the Thematic Homicide Review that clinical staff did not have sufficient time in which to think about the implications of the information they had collected about service users in the course of their work and to record this. We knew that in some trusts clinical staff have protected time every day to bring their records up to date.

The Trust's approach to the recommendation

9.4.2 The Trust has addressed this recommendation through four actions:

a) Ensure that clinical risk training is supplemented with case discussions and reflection which supports service improvement, and promotes the use of relapse planning.
b) Introduce risk assessment documentation which incorporates risk reduction strategies that can be incorporated into care plans.
c) Review audit tools to ensure relapse planning is included in the annual care plan audit.
d) Introduce job planning to community staff to provide diarised admin time.

Clinical risk training

9.4.3 At first sight, the Trust's actions do not seem to be aligned with all aspects of the original recommendation (i.e., does not include specific reference to recording 'the rationale for clinical decisions', though from the evidence we have seen there is no significant difference in practice).

9.4.4 The Trust has pursued a multi-pronged approach to clinical risk training. Clinical risk e-learning was completed and has now been published on MyLearning as has been the Clinical Risk Policy which contains a link to the Minimum Standards for Recording of Risk. This might not appear to satisfy the recommendation that staff should record the rationales for their clinical decisions, but 'risk formulations' now have to be a narrative account of how identified exacerbating and protective factors combine to increase or decrease risk. This approach is to make clear that the reasoning is the outcome of assessing and weighting the available information and requires staff to move beyond a 'tick box exercise'. The Policy on a Page version summarises the longer policy document and ends with the important exhortation of 'when in doubt – ask'.

9.4.5 The Trust appointed a Clinical Lead for Clinical Risk Training in September 2018, and that post holder has been busy ever since. According to the most recent figures, in excess of 660 members of staff have received face-to-face risk training which has been tailored to the needs of the various geographical and/or task areas. These training sessions have been evaluated in terms of relevance to each respondent's job, and staff state that they feel more confident in improving patient safety, in using service user consent to share information, in collaborating with carers, in positive risk-taking, in risk formulation and crisis planning. This type of training has been provided for HCAs and support workers as well as for qualified nursing staff. (See also para 9.2.21)

9.4.6 Funding is now being sought to make this a permanent post.

9.4.7 2,718 members of staff are currently compliant with their Clinical Risk training, representing 93% of those who are required to be compliant.

Clinical audit and changes in policy and practice

9.4.8 Minimum standards for the recording of risk screening, assessment and management plans were completed across the Trust in February 2017. These standards apply to all professional groups. There is now a standard location for adult risk screening/assessment on Carenotes and templates are available to help standardise the contents. A time limit has been set for psychiatrists who are also the Lead Practitioner to document the risk assessment and safety plan in letters to GPs – two working weeks. The Trust used CQC assessments made during 2017 to highlight improvements and determine the need for further action. We have seen the results of the Trust's integrated audit of risk and care planning which was completed in 2018. This audit was adopted following the recommendations of an external homicide investigation (Verita 2014).

9.4.9 The audit applied nine clinical risk and six care planning standards to samples of 185 inpatients and 460 community service users. This audit was conducted to a high technical standard, and its results can be regarded as reliable and valid. Overall compliance with the quality standards in clinical risk assessment and management, crisis and contingency planning and care planning was 78%. Trust-wide compliance with valid risk assessments for community-based service users was also 78%. The auditors found considerable variation between teams and wards and across topics within teams and wards. Community teams were found to be 'low' on measures of service user/carer involvement but scored higher on the review of risks and crisis planning. The Trust had planned to undertake a re-audit in 2018-19 to monitor further improvement.

9.4.10 The Trust later decided that the June 2018 re-audit would not be carried out at that time for two main reasons. First, it was decided that future clinical audits would be carried with clinical staff supporting auditors as it had been found that non-clinical audit staff would not know where to look in the various sources for information on compliance. Second, a series of revisions to Carenotes (as described in part above) had been introduced during 2018, and these need time to be embedded before an audit can be carried out usefully. A draft audit tool has been seen by us, and it is both comprehensive and detailed.

9.4.11 An audit of letters from psychiatrists, who are also Lead Practitioners, to GPs was carried out in 2017 when it was found that staff had caseloads of between 80 and 180 service users. The Trust's policy risk assessment policy was previously that a full risk assessment/screening was to be completed for each of their service users. It was not possible to comply with this requirement without losing significant amounts of clinical time when there were recruitment problems, and academically the effectiveness of risk assessment tools as predictors of future risk were being questioned[12]. On the other hand, the CQC require the Trust to demonstrate evidence of risk assessments/screenings being carried out. Compliance with risk assessment policy has been audited through an investigation of psychiatrists' letters to GPs, and some were found not to be meeting appropriate standards. Services which used a standard template performed more consistently, and this model has now been adopted across the Trust.

9.4.12 More recently, the Trust has been working with the Oxford Health NHS Foundation Trust to introduce a revised version of the risk assessment section in Carenotes. This section of Carenotes contains a comprehensive list of risk factors and staff can now distinguish between issues 'not assessed', 'risk identified', 'no risk identified' and 'unable to assess' (for example, when the service user lacks capacity). This method of recording avoids the problem of the absence of evidence being confused with evidence of absence of a risk factor.

9.4.13 The Trust has been working towards an updated risk assessment tool that is both simple and suitable for use across the Trust. A major obstacle to these

[12] Carter G, Milner A, McGill K, Pirkis J, Kapur N, Spittal M. Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. The British Journal of Psychiatry, 2017; 210: 387-95

objectives is the problem of the workload implications for psychiatrists and some nurses with caseloads of around 150 having to complete the new tool for each service user. Work has been done to establish the time needed for completing the new tool. The Trust is also addressing the problems found in the use of the risk event form which is often loaded with either too much or too little information. The space available for completion is being changed to force staff to be more succinct. The revised risk assessment tool was implemented in December 2018, along with new guidance and training for staff in its use.

9.4.14 We have seen the revised GP letter proforma which includes sections for any new ICD 10 diagnosis together with space for any historical information. The letter has sections for comorbidities; the names of the care coordinator or the lead practitioner; medications; follow-up arrangements; safety/crisis plans to include risk assessment; physical health care plans; and a brief history and summary of the service user's mental state examination. The proforma includes prompts and points for consideration when completing this final section. There is also the opportunity to record each area of risk and 'no risk' can be distinguished from 'not able to assess'.

Protected time for administration

9.4.15 The Trust has a 'Job Planning Policy – Medical Staff (non-training grade)' ratified in 2015 which is now under review. We have also seen job plans for full and part-time post holders as Occupational Therapists (OTs), Assertive Outreach Team staff, and Assessment and Treatment (A&T) Support Time and Recovery Workers (STRs). All of these refer to the requirement that clinical work directly with service users has to be backed by clinical administration. In each of these job plans, while clinical administration time is mentioned, face-to-face clinical work is thought to cover work directly with service users, and it includes assessment, treatment, routine report writing as well as time for preparation, routine administration and travel. It does not establish diarised time in the sense of protected time which we thought essential if good quality reflective records are to be kept as a step towards good quality risk formulation and crisis planning.

9.4.16 The Trust operates on the assumption that for clinics the rate of 'Did Not Attends' enables some clinical administration to be conducted during routine clinic time. The Trust is going to use 'DNA' data to inform its job planning of administration time.

9.4.17 The Trust's supervision policy includes an expectation that supervisors will cover the quality of note-keeping and regularly review a random selection of each supervisee's records, thereby maintaining a focus on record-keeping – but this does not explicitly address the issue of diarised time.

9.4.18 The Trust has ambitious plans for quality improvement, based on a King's Fund report on quality improvement in mental health, in terms of problem-

solving, continual learning and adaptation which recognise the need for an infrastructure to support innovation[13].

9.4.19 The Trust has struggled to implement protected time for record-keeping across the Trust due to the pressure of workloads. It has responded to this situation by looking at how staff can be supported at a local level. Some teams have used job plans to identify the time available for record keeping while others have taken a less structured approach. The Trust has used the Quality and Safety Reviews to ask teams how they protect staff time and several have come to agreements as a team on how to achieve it. Other teams have used supervision to monitor time for record-keeping.

9.4.20 Team managers now have a real-time dashboard for caseloads – reports can be 'pulled through' from Carenotes for each member of staff. Managers can see the number of cases allocated to each team member, can list individual caseloads, can see whether cases are open or inactive (practically discharged but not yet recorded as such on Carenotes), the number of DNA appointments, the status of risk assessments and care plans.

9.4.21 Carenotes is being developed so that information can be captured once and used for more than one purpose. For example, risk assessments and care planning data can be transferred automatically into letters for GPs. The intention is to streamline processes as much as possible.

9.4.22 The new 'updated' risk assessment form on Carenotes takes less time than previously to complete and work is underway to make similar changes to the care planning section. More work on these approaches has been done among inpatient services and the plan is to move on to the community teams next.

9.4.23 We conclude that the Trust has gone some way towards tackling the problem of how to improve the quality of record keeping and the recording of notes. The technology of recording in the shape of Carenotes has been scrutinised and improved with advice and experience from another Trust, but it has yet to tackle the issue of the opportunity for staff to keep good records. The daily pressures of caseloads and busy clinics which have large numbers of staff vacancies are resource issues beyond our remit.

Five per cent sample of current cases

9.4.24 We asked the Trust to provide us with a random sample five per cent of working-age service users in the community so that we could investigate the extent to which CDSs were carrying out comprehensive risk assessments, completing risk formulations, devising crisis/contingency plans, reviewing risk and producing care plans and interventions for service users. The Trust routinely collects and records information on these Fundamental Standards of Care. The Trust initially produced information on 120 cases but six of these were found to be under the care of the Children and Young Persons CDS and these were excluded as there were no similar cases in the Thematic Homicide

[13] Ross, S. and Naylor, C. (2017) 'Quality improvement in mental health' The Kings Fund, London, p. 32

Review (see Appendix D for details). The Trust anonymised all information about these cases prior to sending it to us.

9.4.25 Twenty-one of the 114 cases were defined as 'high-risk or complex'[14] cases (hereafter referred to simply as 'high-risk') according to Department of Health criteria and the remainder were described as either 'low-risk or not complex' level of risk[15]. Risk level has been used as one of the two major ways in which the data from this sample have been analysed. The other variable used for analysis is CDS. A brief synopsis of the results is presented here.

9.4.26 Where comprehensive risk assessment was concerned the data show that:

- All but one of the 21 'high-risk' cases had a risk formulation containing a narrative of how identified risk and protective factors combine to increase or decrease risk compared to 89 of the 93 'low-risk' cases.
- All of the 'high-risk' cases had the nature of the risk(s) recorded in Carenotes compared with all but one of the 'low-risk' cases (21 out of 21 compared with 92 out of 93).

9.4.27 Under the heading of risk management, the data show that:

- All but two of the cases, regardless of risk level, had a risk management plan which demonstrated an understanding of the factors or events that increase risk together with a statement of how likely they are to occur compared with one of the 'low-risk' cases (20 out of 21 compared with 92 out of 93).
- In 18 out of the 21 'high-risk' cases the risk management plan demonstrated an understanding of what to do following an increase or decrease in the risk shown by the service user compared with 86 out of the 93 'low-risk' cases.
- Twenty of the 21 'high-risk' cases had a risk management plan which targeted identified risk factors and they documented strategies or interventions aimed at preventing identified potential adverse risk events from occurring and/or minimising the harm caused compared with 88 out of 93 'low-risk' cases.

9.4.28 When staff were expected to record details of crisis/contingency planning in case of relapse:

- Ten out of the 21 'high-risk' cases had a crisis/contingency plan which included personalised signs and symptoms of relapse and/or deterioration mental health compared with 44 out of the 98 'low-risk' cases.
- Completion rates were high for both risk groups when it came to the personalised crisis/contingency plan having specific personalised advice for

[14] High risk is defined by the Department of Health and Social Care as 'This represents a risk of committing an act that is either planned or spontaneous, which is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce that risk. The service user requires long-term risk management'.

[15] Low-risk is defined by the Department of Health as 'The service user may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. He is likely to cooperate well and contribute helpfully to risk assessment. He is likely to cooperate well and contribute helpfully to risk management planning and he may respond to treatment. In all probable future scenarios in which risk might become an issue, a sufficient number of protective factors (e.g. rule adherence, good response to treatment, trusting relationships with staff) to support ongoing desistance from harmful behaviour can be identified'

the service user on what action to take if a crisis occurred either in and out of working hours (21 out of 22 compared with 93 out of 98).

- Eighteen of the 21 'high-risk' cases had a crisis/contingency plan with specific information for relevant others (family, friend and/or carers) on what action to take if a crisis occurred either in or out of working hours compared with 69 out of the 93 'low-risk' cases.

9.4.29 Risk is dynamic and the need for it to be reviewed regularly and recorded is important:

- Eighteen of the 21 'high-risk' cases had their risk assessment updated appropriately (for example, due to changes or incidents), or at least on a 12-monthly basis for those service users on CPA compared with 63 of the 'low-risk' cases.
- Eleven of the 21 'high-risk' cases had their risk reviewed and noted at each of the last three clinical reviews they had attended compared with only 23 of the 'low-risk' cases.

9.4.30 In the area of care planning and clinical interventions:

- There was no difference between the two groups as all Personal Support Plans clearly showed a description of the actions to be taken and by whom in the event of a crisis.
- Nineteen of the 21 'high-risk' cases had records which demonstrated that planned interventions had been or were being carried out by a clinician compared with 91 out of the 93 'low-risk' cases.
- There was a clear description in the care plan of planned interventions and/or the rationale for interventions in all but one of the cases in each risk group (20 out of 21 and 92 out of 93 respectively).

9.4.31 The sample was spread across the four adult CDSs but we are not making any claims about representativeness. There were 26 Brighton and Hove, 38 Coast West Sussex, 23 East Sussex and 27 North West Sussex cases. There were some differences between the CDSs:

- Crisis/contingency plans contained personalised signs and symptoms of relapse and/or mental health deterioration in less than half the total sample (56 out of 114), both Brighton and Hove and East Sussex CDSs had a majority of cases with completed personalised contingency plans (16 out of 26 and 12 out of 23 respectively).
- There was little variation between the CDSs as to whether the crisis plan included specific advice for the service user on what action to take in a crisis in and out of working hours.
- There was some variation between the CDSs when it came to specific information for relevant others if there was a crisis either in or out of
- working hours with Brighton and Hove performing best followed by Coastal West Sussex, North West Sussex and Coastal West Sussex.

9.4.32 Some variation was noted in the review of risk:

- Most cases had their risk reviewed appropriately (86 out of 114) with East Sussex performing best followed by North West Sussex, Brighton and Hove and Coastal West Sussex.
- Risk had been reviewed and noted in each of the last three clinical reviews in 37 out 114 cases with East Sussex performing best followed by Brighton and Hove, Coastal West Sussex and North West Sussex.

9.4.33 The analysis of the five per cent sample of working-age adults in the community show the Trust is performing well in the areas of risk formulation; recording of risk management; risk management planning; and, the identification of protective and trigger factors and creating strategies and interventions to reduce risk and/or harm; the specification of personalised advice for the service user in case of relapse or crisis in or out working hours. Its performance is less satisfactory in terms of personalised crisis/contingency planning advice for family and friends carers; risk assessments are not always updated appropriately; risk assessments as not being recorded as regularly as they might. There is some variation in performance depending on the level of risk shown by the service user and depending on which CDS the service user attends.

9.4.34 The Trust knows from its Integrated clinical risk and care plan clinical audit March 2018 and the Integrated Performance Reports that variations exist between CDSs. We would suggest that the Trust should analyse its clinical audit data in terms of risk/complexity in future to ensure that 'high-risk or complex' cases are being assessed appropriately and their details recorded in accordance with their level of risk. It might also be advisable for managers to use this information as a tool when supervising their staff.

Conclusions

9.4.35 The Trust has been successful in implementing some aspects of this recommendation. It has improved training for staff on the quality of risk assessment and recording through the employment of a clinical lead for risk. Minimum standards for recording risk screenings, risk assessment and risk management plans have been adopted across the Trust for all professional groups. The Trust has introduced a proforma letter for psychiatrists to use to communicate their assessments in a standard form to GPs.

9.4.36 Some work has been done in protecting staff time for record-keeping and other administrative tasks through job planning but it isn't clear what proportion of the clinical workforce this covers. The amount of recording required has been reduced somewhat through changes in the assessment forms themselves. Many teams suffer from high caseloads and the situation is made worse by high levels of staff turnover and sickness absence. Some teams have been given the responsibility of finding their own local solutions to protect administration time.

9.4.37 A clinical audit was carried out in 2017/18 which found that there was considerable variation between the CDSs in terms of completion of these

important aspects of care and treatment. Our own five per cent sample of adult-age service users in the community showed that recording information on 'high-risk or complex' cases was very nearly complete, there were some variations around involving carers. When we looked at the whole sample by CDS there were also variations between the CDSs which echo those of the Trust's own clinical audits. These data show improvement since 2016.

Recommendation 4: Implemented to Level 2 – partial. (There is evidence this has been implemented in some cases but it is not clear how widespread this is.)

9.5 Recommendation 5

"The Trust should investigate the feasibility of technological solutions to make it easier to complete records and improve productivity. This might include the use of voice recognition technology when recording on the electronic record system."

Background to the recommendation

9.5.1 This recommendation was made for reasons similar to Recommendation 4, if record keeping was to be improved and encouraged by the Trust then the means to these ends ought to be made available. Staff who complete records and assessments may be unlikely to be competent typists and voice recognition technology was suggested as one way of achieving good quality records, or at least as a means of reducing the disincentives to producing good records.

The Trust's approach to the recommendation

9.5.2 The Trust has tackled this recommendation through five actions:

a) To complete a pilot with clinicians for the use of Dragon Dictate to aid automatic input into the electronic patient record (EPR) and other key application.
b) To ensure Dragon Dictate is available on the 'IT catalogue' for all services to choose, along with training where required.
c) To improve the uptake of digital dictation across the trust, now that Carenotes (EPR) has been implemented.
d) To explore other methods to aid with automated, or easier, input into the trust's key application, for example, use of Apple and Microsoft tools.
e) To agree what needs to be recorded in relation to diagnosis (primary presenting mental health problem) then review and make any necessary changes to Carenotes to enable recording of a primary diagnosis for all patients and to ensure appropriate training is in place to support the recording of diagnosis.

Improving record keeping

9.5.3 In many ways, this recommendation follows on from Recommendation 4 as we thought that the Trust should look for ways to help staff complete records and letters in the easiest possible ways. This approach assumed that very few staff in clinical grades would be effective typists and that voice recognition technology could provide a quick, effective and relatively pain-free means of achieving a broader objective.

9.5.4 In January 2019, the Trust reported that some 507 staff had registered over the previous 18 months to use Dragon Dictate. Dragon Dictate had been available to Trust staff previously but it had been seen and used as an 'adaptive technology' solution[16]. Staff are initially registered for a 30-day free trial before going on to hold a full licence to use the system. Three hundred and sixty-eight of the staff had a full licence and 151 licences were still available.

9.5.5 Dragon Dictate is available on the Trust intranet for all staff who wish to use it. The Trust has surveyed its staff on their use of Dragon Dictate and found in September 2018 that staff were at different stages in their use of the system. Of the 87 respondents, 38 were nurses, 19 were doctors, seven were psychologists, four were OTs, and two were speech/language therapists. The remaining 11 respondents included a social worker, a mental health practitioner, a team leader, a care manager, an assistant psychologist, a support worker and a nurse manager.

9.5.6 Dragon Dictate users were asked what they were using the system for? There were 70 responses that it was being used to dictate patient information into Word documents for letters and reports, there were 51 responses for its use in 'entering information into Carenotes', 17 for 'emails' while 11 'other' responses included using it for writing strategic reports, triage notes, and combinations of all the preceding uses.

9.5.7 Staff were asked both how frequently they used Dragon Dictate and how difficult they found it to use. Most (60) respondents said they used the system less than daily but more than once a week. Forty-nine said that they found the system difficult to use. The majority (72) found its use had some or more improvement in their ability to do their work when compared with the previous system for recording information. Many, but not all, found that they saved time using Dragon. The vast majority (78) said they would recommend it to their colleagues. When asked supplementary questions about the system, 14 said that they experienced problems with the system's accuracy, 13 said that there were problems of background noise and other problems when they used the system in shared rooms or when they were hot desking. In these circumstances, the system sometimes picked up other people's voices and added what they were saying to the text.

9.5.8 The Trust has tried to improve uptake by putting on a number of demonstrations of the system and has used the Partnership Bulletin and the intranet to promote the availability of Dragon Dictate.

[16] For staff with a disability.

9.5.9 We have received information from the Chief Clinical Information Officer that in one CDS the majority of the doctors use Dragon Dictate, and this has a positive impact on the turnaround times in relation to clinic appointment letters being received by GPs. In the past, medical secretaries were regularly working two to three weeks behind clinics in sending out letters to GPs. Now, most of these letters are sent out within a week of the clinic. For those doctors using the traditional dictation/transcribing method the turnaround time is still on average two weeks. In a document relating to the Global Digital Exemplar Community (2019) the results of the survey of users expresses information in a different way and suggested that 32% of users saved one to two hours per week using the system, 25% said they saved three to five hours a week and 5% said they saved over five hours a week.

Lessons learned from innovation

9.5.10 In the process of introducing this innovation, the Trust has learned a number of important lessons:

- Clinical professional staff needed to be engaged from the outset in discussions of the project. Doctors seem to have gained most from the use of this technology. Doctors were most comfortable using voice to text as it aligned more with their workflows and they were more experienced in formulating clinical letters in their minds as they dictated.
- Moving to a paperless system generated a great deal of emotion. Clinical workflows are heavily dependent on paper-based systems, and the Trust's mandate to change forcefully brought to the fore many staff concerns.
- Administration staff need to know how changes like this will affect them and their work and, therefore, they need to be consulted at an earlier stage. Senior managers in the Trust knew from their involvement with the Thematic Homicide Review what motivated the change, but others did not. The conclusion drawn is that staff engagement needs to begin earlier rather than expecting it to emerge at the promotion stage of any project.
- The working environment had a significant impact on usage, as dictating impacted others in open plan offices and confidentiality issues were also raised which means that the Estates department should have been involved from the outset.
- There should have been a Trust mandate for the introduction of the technology as its use remains optional.

9.5.11 The Trust has, in effect, evaluated their experience with implementing voice to text technology as part of their involvement in the Global Digital Exemplar Community initiative[17]. NHS England is currently supporting seven digitally advanced mental health trusts through funding and international partnership opportunities to become Global Digital Exemplars. The Trust is linked to the Oxford Health NHS Foundation Trust to accelerate its digital maturity. The aim is that Exemplars will provide proven models that can be rolled out across the NHS more broadly.

[17] For more information see NHS England Digital technology exemplars

Alternative approaches to record keeping

9.5.12 The Trust made available over 1,000 iPads to help support staff input information into Carenotes, particularly when 'on the move'. The Carenotes mobile app has not met all the requirements. Staff have been encouraged to use their laptops with a 4G mobile data device.

9.5.13 As well as introducing voice to text dictation, the Trust has also been adding new fields to Carenotes to improve the recording of diagnoses. In an audit of letters to GPs, completed in March 2019, the Clinical Audit Department found that the recording of the diagnosis had risen from 76% in 2017/18 to 98% in 2018/19. The national standard across primary and secondary mental and physical health diagnoses is 90%. In community services, most standards are met with the exception of letters communicated to GPs within two days of the patient being discharged. The Trust carried out a major project to improve the recording of the 'main presenting mental health problems' and then to match this with ICD10 codes (the International Classification of Diseases 10th revision). By March 2019, all the community CDSs were in the range of 56% to 70% with three of the four at 69%, 69% and 70%.

Conclusions

9.5.14 We conclude that the Trust has not only introduced a voice to text dictation system (Dragon Dictate) it has evaluated its use across the Trust and has learnt a number of valuable organisational lessons on how to introduce a major, sustainable, technological change. This is important as the Trust moves forward in its use of technology to improve service provision. The Trust has paired up with the Oxford Health NHS Foundation Trust as part of the Global Digital Exemplars Project which is an important indicator of its willingness to innovate and learn from others' experiences. Clinical staff's performance in completing records and improving productivity have both improved in ways the Trust can measure. The Trust has gone beyond the demands of our recommendation and we commend the Trust in their efforts to roll out the voice to text system more comprehensively.

Recommendation 5: Implemented at Level 3

9.6 Recommendation 6

"The Trust should consider developing a checklist of key requirements, based on the themes identified in this report, to be used in all CPA reviews."

Background to the recommendation

9.6.1 In the course of the Thematic Homicide Review, we found several instances of CPA reviews that did not consider anyone other than the service user themselves. Opportunities to involve carers and/or families were not pursued.

There were also examples of the reviews being largely in-house in the sense that other agencies involved in the service users' care and treatment were either not invited to attend or that an invitation was sent out so late that the other agency could only rarely attend. The rationale behind suggesting a checklist was that supervisors could use it to establish a baseline for judging the quality of the CPA reviews carried out in their service.

9.6.2 The Trust had a checklist in its CPA policy document of 2016 as Appendix 1 'Personal Support Plan Preparing for a Review – Checklist'. The document explained that CPA reviews were an opportunity for the service user to tell their care team how they were getting on and to consider what care and treatment would suit the service user best. The checklist was compiled to help the service user prepare in advance of the meeting. It explained that not all the points might be relevant to each individual and that there might be other things the service user wanted to talk about; it also suggested that they might find it worth going through the checklist with their lead practitioner, a friend or carer before the review meeting. The checklist consisted of 12 topics; some of which were advice (about bringing a friend or relative or an independent advocate) through questions about medications to relapse planning.

The Trust's approach to the recommendation

9.6.3 The Trust addressed this recommendation in two ways:

a) To develop in partnership with patients and carers a simple quality checklist that can be used in every CPA (Personal Support Plan) review. That meets the needs of all involved and can be utilised to ensure quality and completeness.
b) To investigate/request upgrade to Carenotes (EPR) to include a 'completed checklist' tab to allow for monitoring and audit.

9.6.4 As recommended, the Trust did consider developing a checklist for staff to use at CPA reviews. Following this, they concluded that their preferred approach would be to focus on 'the things that really matter to people' which were a person-centred, recovery-oriented, collaborative (involving service users, carers and professionals) approach to care planning.

The work of the Care Planning Quality Improvement Group

9.6.5 In May 2017, the Trust's Care Planning Quality Improvement Group (CPQIG) began to tackle some of the issues raised in the Thematic Homicide Review to do with getting service users to the proper level of expertise for their problem(s). The Thematic Homicide Review had identified systemic or professional problems such as the staffs' lack of knowledge of the Mental Health Act and that staff were not sufficiently skilled in their use of its provisions. Similar problems with the staffs' skills and abilities in carrying out good quality risk assessments and then generating well developed and robust crisis management plans were also found.

9.6.6 The Trust's CPQIG concluded that these concerns could be incorporated into a simple, user-friendly checklist to be used at CPA review meetings. The service user and carer representatives, however, felt strongly that this should not be part of the Carenotes system but should be sent to each service user as part of the invitation to the review. The Improvement Group produced an implementation plan with a timetable. Their plan included incorporating the checklist into the revised CPA policy, amending the current Personal Support Plan to include a section for service users' and carers' comments. The plan also included monitoring the roll out and use of the checklist.

9.6.7 The Trust held three engagement events to improve care planning. The Trust used independent facilitators' expertise in creatively accessing people (service users, carers and staff) so they could be asked – 'what should a good care plan look like?'. The response was that the ideal was a care plan which was a three-way co-production, making people feel valued and involved in the care planning process. Ideally, care plans should identify what is working well and should have specific details about what people do not like or do not find helpful. The aim is to keep care plans alive for everyone and relevant to all parties involved.

9.6.8 The events are based on 'understanding that the irony of the failure of care planning is that it can lead to a serious incident and a serious incident investigation is a very person-centred activity'. The independent facilitators' aim was to make sure service users (known as 'peers') are involved as an essential component.

Personal Support Plans

9.6.9 The Trust has held training events to explore the idea of co-produced Personal Support Plans (PSPs). The Trust used a model based on work done at the South London and Maudsley NHS Foundation Trust to train clinical staff and peer trainers in collaborative care planning for community adult services. The training is reported as being well received.

9.6.10 The Policy on a Page version of CPA has been amended to state why the policy is needed – the Trust must provide assurance that all service users will have their mental health and social care needs assessed and will be involved in developing a care plan (the PSP) that addresses identified needs and any assessed risk associated with their situation. Service users will be allocated a care coordinator (a lead practitioner) and the PSP will be reviewed regularly (at least annually). The lead practitioner will be the service user's main contact with services, and they will work together to agree a Care Plan/PSP.

9.6.11 The Trust's PSP consists of four parts: 'my keeping well plan', 'my plan for managing ups and downs', 'my plan for moving on again after a crisis', and 'my plan for pursuing my ambitions and dreams'. The Plan has space for the service user's own contributions as well as pre-printed sections. In addition, there is 'Personal Support Planning – working together to agree your care' which explains why a PSP is needed, the differences between standard care and CPA, what can be expected of lead practitioners, the involvement of carers and others offering support and how to get in touch with services. The PSP is

also available in nine languages as well as BSL, Easy Read, Braille, Large Print and Audio.

9.6.12 The Trust has established quality standards for PSPs which should:

- be collaboratively written
- be personalised to the individual
- have clear goals of treatment with action owners, timescales and milestones
- include evidence-based treatment/intervention, in line with NICE guidelines and best practice with clear description and clinical rationale for treatment and services offered
- involve carers and supporters in developing and delivering the overall PSP to the individual. Carers should be offered an assessment of their needs
- confirm plans on Carenotes as soon as possible and shared with the service user (and others as appropriate) within five days of completion
- be reviewed in line with cluster[18] review period – a minimum of annually in the community
- be in the approved format for the CDS/type of care the service user is receiving, and in the correct place in the electronic care record.

Auditing care plans

9.6.13 The Care Planning Quality Improvement Group (at its January 2018 meeting) reported that services with a less than an 80% compliance rate on care plans should be re-audited within three months. Concerns were raised about the staffing demands imposed by rapid re-auditing. This Group made links between compliance rates and pre-registration and in-house training. The lack of any basic care planning training has been a longstanding issue. The Group noted the need for ongoing training which is responsive to people's needs. The Trust had recently bought a training package from the Care Coordination Association but the Group stated that there was a need to develop some online training in the same way as that for risk assessment and management training had been developed. The contents of the care planning training have been seen and fit well with the training need that had been identified.

9.6.14 In May 2018, the Trust began to develop a new community care plan template for Carenotes. The Community Care Planning Group established what was required in a care plan and were then planning to obtain a care plan form from another Trust which already uses the Carenotes template. Additionally, links would then be made to the appropriate NICE guidance. The Group also drew up a list of resources that staff could access, for example, quality standards from NICE, tools and resources from NICE, NHS Choices, Mind, the National Survivor User Network, and others. The Group reviewed each of the documents extracting the significant points for providers of care. They also looked at guidance and standards of care which are disorder-specific – bipolar,

[18] A cluster is defined as: "a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool". Source Mental health clustering booklet (2016/17) NHS England.

psychosis and schizophrenia in adults. The Group stressed that care plans had to be person-centred and co-produced.

9.6.15 In March 2018, the Trust published its 'Integrated clinical risk and care plan clinical audit' which showed that just over 50% of all adult service users had a valid PSP in March 2018 compared with just under 40% in May 2017. The rates of completion of a valid PSP were higher for the adult community CDSs than the adult services overall. In March 2018, the rates were approximately 62%, 55%, 52% and 30% for Brighton and Hove, Coastal West Sussex, North West Sussex and East Sussex respectively. Three of the four showed improvement over the previous May; though in Coastal West Sussex the rate had fallen back from about 69% to about 54%.

9.6.16 In January 2019, the Trust set up a working group to review current evidence and best practice for care planning across the Trust and among other mental health trusts with the aim of developing a single co-produced care plan that every service user will have across the Trust. The aim is for a single care plan for each service user to be developed from the point of entry and to include all acute and community care received from the Trust. The Group will be chaired by the Chief Medical Officer with the aim to conclude in six months. The Group will report to the Service Delivery Board.

9.6.17 In our own five per cent sample of current cases of working-age adults in community services, we found that a PSP had been completed in every case irrespective of risk or complexity of the case, or between the CDSs.

Conclusions

9.6.18 The Trust did consider the use of a CPA review checklist and decided that this was not the most appropriate way forward. The Trust has produced a checklist for service users and carers which they can use to contribute to CPA reviews. This is not the local tool, as recommended, which staff could use to prepare for the CPA review which management could then use locally to audit the CPA process.

9.6.19 However, the Trust has accepted the requests of service users and carers and has accepted the need for Personal Support Plans to be co-produced with service users and carers. The Trust has worked on developing a person-centred, recovery focussed approach to care planning.

9.6.20 The difference between our recommendation and current practice is that managers have to wait until a Trust-wide audit to know how local services are performing. In addition, the Trust has committed considerable resources to training in this area; and the results of routine Trust data collection and our five per cent sample suggest that performance in this area has plateaued below the Trust's target. There is now a QI project in place to improve performance across the Trust.

Recommendation 6: Implemented at Level 3

9.7 Recommendation 7

"When the Trust evaluates training and education, they should evaluate not only the learner experience but also the impact of the training, using a model such as Kirkpatrick:

Level 1: Reaction (Staff enjoyed and engaged in the training)
Level 2: Learning (Staff acquired the intended knowledge, skills and commitment from the training)
Level 3: Behaviour (Staff apply what they learned back in the workplace)
Level 4: Results (Achievement of organisational targets or goals as a result of the training)."[19]

Background to the recommendation

9.7.1 The Thematic Homicide Review found that a frequent recommendation was for more training (for example, in needs and/or risk assessment, in risk management and in developing a crisis plan). However, many of the aspects of practice that were identified as being of poor or variable quality were already part of initial training and in-service professional development. We concluded that the implication seemed to be that training in its then-current shape was not doing what was expected of it.

9.7.2 This recommendation is also consistent with Ross and Naylor[20], writing specifically in relation to quality improvement:

> "As one medical director pointed out, without the infrastructure to support quality improvement, any type of training for staff will be like 'throwing seeds on fallow ground'."

The Trust's approach to the recommendation

9.7.3 The Trust approached implementing this recommendation by means of the following actions:

a) Review current training available using Kirkpatrick's model ensuring training, development and education is purposeful, meaningful and is used to improve patient care.
b) Ensure learning is supported by good quality supervision, reflection, Action Learning sets and clinical forums enabling a culture of constant learning and evaluations.
c) Use service user and carer feedback to measure the impact of training on their experience of services supported by 360º feedback.
d) Ensure regular reviews and monitoring of all training delivered and ensure changes are made as a result of the outcome.
e) Introduce team-based training to focus on findings and actions from Thematic Review.

[19] For full information about the Kirkpatrick model, see Kirkpatrick Partners
[20] Ross, S. and Naylor, C. (2017) 'Quality improvement in mental health' The Kings Fund, London, p. 32

9.7.4 We note that, since the Thematic Homicide Review and Trust action plan were developed, training and education has been brought within the remit of Organisational Development as part of the Human Resources and OD Directorate.

9.7.5 Since the Thematic Homicide Review was written, the Trust Board has led significant changes in the culture of the organisation which are described in detail in para. 2.4. These changes are particularly relevant here, because training has become one component of the QI, OD and TDD activities, rather than an activity to be evaluated as an end in itself. The overall focus of all these activities is improving care and treatment, and patient safety. We have, therefore, assessed the evidence provided by the Trust for this recommendation in light of this move towards culture change.

Ensure training, development and education is purposeful, meaningful and is used to improve patient care

9.7.6 The Trust has not used Kirkpatrick's model (or similar), as suggested in our recommendation. However, they have used a number of alternative approaches to aim for similar outcomes.

9.7.7 Following the Thematic Homicide Review and in response to the recommendation, the Trust carried out a specific project to evaluate the clinical risk e-learning package against levels 1 and 2 of Kirkpatrick[21]. They identified this package as one that could be evaluated and used as a pilot to inform a strategy for assessing the impact of training on practice; and the subject area was relevant to the Thematic Homicide Review.

9.7.8 Risk training is based on e-learning and is mandatory for all clinical staff and HCAs in contact with service users. Mandatory training must be completed every three years and students must achieve at least 80% in the assessment. The Trust has re-introduced face-to-face training to complement the e-learning but it cannot be the only method of training because of the resource implications. In addition, CDSs are developing other models of training, including reflective practice, risk circles and complex case discussions.

9.7.9 The authors of the report of this study note that, being interviewed within three months of accessing the e-learning Risk Training, practitioners had been able to retrieve some of the learning. Practitioners felt more confident when carrying out risk assessments following the training and considered that the use of additional methods of learning and development to complement the e-learning was necessary. The peer trainers asked for more service user and carer information to be included in the risk training, which indicated that future revisions of this training should be co-produced.

9.7.10 The authors felt that:

[21] Education and Training Department (undated) Clinical Risk Assessment and Safety Planning/Risk Management Training: A pilot study of Evaluation of Impact on Practice.

"This will clearly help address one of the recurring themes highlighted in the Thematic Review, that in some cases risk assessments were not completed or they did not use information from family and carers effectively and that the member of staff making the risk assessment did not understand the risk implications of the service user's criminal record. This could be given more focus in the e-learning training to deal with the issues raised in the thematic review."

9.7.11 The authors made a number of recommendations and noted that learning from the evaluation process is to be shared with education and training teams so that this learning will inform the evaluation of the various in-house education and training study days and programmes of study. The following includes the key points from the report's recommendation regarding future evaluations (see Appendix H for details of this report).

- Consideration of further evaluation to measure impact on practitioner skills through the examination of risk plans produced before and after any risk training.
- Involvement of the audit team to sustain this kind of evaluation work.
- Encourage staff who are doing Master's level education to lead on these kinds of evaluations.
- Audit risk plans once the training has been reviewed and revised.
- Once the training is reviewed and revised, audit how this actually impacts – for example having the family more involved in the risk assessment.
- Attendance sheets need to be kept with some way of accurately recording on MyLearning attendance at any training additional to e-learning.

9.7.12 All the e-learning packages now incorporate assessment to check learning with a set pass mark (80-100%). The previous Director of Education pointed out that training needs to result in learning before it can impact on practice.

9.7.13 To ensure their training is purposeful the Trust has mapped their mandatory training courses to Skills for Health core skills framework. In addition, the Trust's annual training plan is developed in partnership with clinical services, and via the education leads group and education governance group. The plan is reviewed and ratified by the Effective Care and Treatment Committee (ECAT) which ensures alignment with the clinical strategy. Professional education leads oversee the professional component of CPD funding and align this to priorities of clinical delivery.

9.7.14 The Trust is promoting Team Development Days (TDDs) as a significant element of shifting organisational culture towards one of listening and co-development of solutions and away from the overly command and control culture of the past. Each team is expected to hold two TDDs each year, with all members in attendance. A video about TDDs has been produced[22], which

[22] Video about team development days

explains the rationale behind these events and provides information about how they are led and the benefits of TDDs (see Appendix H for details).

9.7.15 The draft annual training plan continues to emphasise the importance of TDDs. We note that the annual training plan makes no explicit reference to 'value for money', impact on practice or organisational objectives, or evaluation of the training provided.

9.7.16 Generally, learners are asked to complete a survey following attendance at all training, workshops and conferences. This includes asking if the training was relevant to their work, but not if they anticipate any changes in practice or if it has led to any actual changes in practice. The Trust aims to embed change and impact through supervision. The Education team will be asked to review the evaluation forms and bring a revised form to ECAT for agreement.

Support learning by good quality supervision, reflection, Action Learning sets and clinical forums

9.7.17 The Trust intends to embed the impact of training through clinical supervision and appraisal. The new appraisal policy asks every appraisee 'How has this training added value to the service?'.

9.7.18 We received information on 'Supervision Compliance' – compliance with supervision in the period 1 January 2019 to 7 February 2019 by CDS. This tells us how much supervision there was in each week but no information on how many staff received supervision out of the possible total. Data about medical staff and trainee psychologists are not included. There is a cumulative graph showing what percentage of staff had had a supervision session. The data shows that there is large variation within and between CDSs.

9.7.19 Information on monitoring Mandatory and Statutory Training (MAST) was provided, including a compliance report to the EMC (January 2019) and to the ECAT (May and July 2019). These reports indicate that achievement of targets for compliance with e-learning targets (of 85% compliance) increased over the period, with compliance at 100% by June 2019. Completion of courses ranged from 88% to 95%. Compliance for face-to-face training was less good, with rates of non-attendance also monitored. The Trust response to non-attendance at two PMVA courses is to commence a DNA QI project to see if they can make improvements. The report for the July 2019 meeting also included summary compliance rates for recording supervision (55%) and appraisal (34%) for the Trust as a whole. We expect that the Trust will be considering ways to improve these percentages.

9.7.20 These compliance reports demonstrate the Trust's commitment to monitoring compliance, identifying where action is required and ensuring that action is taken. This information is reported through ECAT to the Quality Committee and from there to the Trust Board.

9.7.21 The Trust operates the MyLearning computerised system for managing training and education. Functions of this system include the facility for staff to

log supervision and appraisal, and for line managers to monitor their staff's completion of training, supervision and appraisal.

9.7.22 The Trust believes that they have significantly shifted the organisational culture through supervision, appraisal, professional leadership and reflective practice. The evidence base for training impact strongly suggests supervision is the most effective vehicle for delivering this. One example is the Preceptorship programme (for newly-qualified and newly-appointed nurses), which incorporates 14 study days over 12 months (see also para 9.2.20).

9.7.23 These study days incorporate reflective practice sessions at the end of each day.

9.7.24 The Education Governance Group prepares an annual education quality and performance report. Progress and exceptions are reported through the Quality Committee.

9.7.25 The August 2018 half-year report describes the state of education and learning across the Trust against the quality standards produced by ECAT and agreed by the Quality Committee[23]. The standards are consistent with the Trust's clinical strategy (see also paras 9.1.12 and 9.1.13). For each standard the report covers:

1. Whether the standard has been met.
2. Evidence of current performance.
3. A maintenance or improvement plan.

9.7.26 The report covers standards relating to the provision of:

- training required for staff to deliver effective care, support and treatment
- high quality educational and practice learning opportunities for the future workforce
- public education that is co-produced and supports wellbeing and recovery.

9.7.27 This is a detailed report which addresses the extent to which these standards have been met and plans for improvement (where compliance is partial or not met) or maintenance (where standards are met). The primary focus of the report is on what is being provided rather than evaluation of impact on practice[24]. Clearly, the impact cannot be evaluated until provision meets the standards set, but we hope that measurement of impact can be considered once provision standards are met consistently.

Service user and carer feedback to measure the impact of training on their experience of services

[23] These standards are 'inclusive of and map closely onto the Key Lines of Enquiry (KLOEs) on education and learning defined by the Care Quality Commission'. Education Quality and Performance Report, Effective Care and Treatment: Half-year report August 2018, p 1

[24] Although not specifically related to clinical practice, a longitudinal evaluation study of an arts and heath programme provid ed through recovery colleges provides a good example of evaluating impact through self-report.

9.7.28 The Trust has a system of Clinical Academic Groups (CAGs). These groups design menus of care for different care pathways, such as psychosis, and Experts by Experience are involved in development of the pathways through membership of the CAGs. The function of the CAGs includes feedback on the impact of new interventions which are delivered by staff who have participated in the relevant training. We were given a list of service users and carers who are members of CAGs, and who are engaged in evaluating the impact of new interventions.

9.7.29 These arrangements demonstrate the Trust's commitment to and action to implement effective and meaningful involvement of service users and carers Trust-wide – this includes using feedback from them to understand the impact on their experience of services of some training.

Regular reviews and monitoring of all training delivered, leading to change

9.7.30 The function of the Trust's ECAT is 'to make services more effective; providing evidence-based, recovery-oriented care and treatment, supported by research and education activity'[25]. The Committee reports to the Quality Committee and will provide an update on progress to the Quality Committee quarterly and to the Trust Board twice a year. Membership includes a service user consultant and a carer consultant as well as representation from the CDSs, the Director of Training and Education and the Clinical Director – Clinical Strategy. A sample of the minutes of these meetings lists these individuals as either present or sending apologies.

9.7.31 The Trust carried out an 'Integrated clinical risk and care plan clinical audit' which reported in March 2018. The audit was based on a sample of 645 records across the Trust (geographically and by function), of which 185 were by in-patient teams and 460 by community teams. Data was collected by the audit team in Quarter 1-2 of 2017/18 (July to September 2017). The records audited relate to service users 'active' within the Trust in April and May 2017. The results of the audits were provided to teams in October 2017 for use to inform their quality improvement programmes (see also paras 9.4.15 and 9.6.15).

9.7.32 Of particular relevance to this recommendation, the audit included completion of clinical risk e-learning (a mandatory requirement for all staff). At the end of March 2018, and where data was available, overall compliance for the Trust was 92%. The CDS with the lowest compliance achieved 85% completion rates; and two CDSs achieved 100%. More importantly, the audit compared results for the Thematic Homicide Review relevant risk standards with training completion rates to identify if there was any correlation between completion of the learning and the validity and quality of risk assessment and management. The audit found no significant correlation at Trust level, with some possible correlations at an individual service level. The key finding in relation to this was that, where there is no significant correlation, the training could be reviewed to 'ensure that staff are supported to complete them to a high quality' (p.11).

[25] ECAT Terms of Reference, undated.

9.7.33 Following identification of 'key risk areas', the report identifies activities for mitigating risk and improving quality.

9.7.34 Overall, this report describes a process whereby risks identified through the audit have led to mitigation actions which include a range of learning activities, including delivery of training about specific risks, some of which is tailor-made on the basis of the audit; direct connection between risks and supervision; use of teams with high levels of compliance to support teams who need to improve; sharing exemplars of good risk assessments, crisis and contingency plans and care plans with teams with lower levels of compliance with the standards. Although the re-audit is currently postponed in order to improve the quality of audit, this model has the potential to demonstrate the impact of learning activities (more broadly defined than just training) as part of a quality improvement model in practice.

Team-based training to focus on findings and actions from Thematic Homicide Review

9.7.35 The Trust has created an Organisation Development Practitioners Service[26]. The aim of this OD programme is to use an 'appreciative inquiry approach' to support teams to focus on improving team dynamics and developing better ways of working. Two cohorts of Organisation Development Practitioners (ODPs) had been trained (42 individuals), supported financially by HEE.

9.7.36 ODPs were involved in a wide range of activities, including six events (TDDs) devoted to the Thematic Homicide Review, all of which were delivered to the East Sussex CDS[27].

9.7.37 The Trust has clearly invested significant resources in the ODP service to support and facilitate all services in implementing OD theory and practice. This is to be commended and demonstrates a serious commitment by the Trust to use this methodology to improve services, care and treatment for their service users and carers, and is an element in 'an infrastructure to support quality improvement'.

9.7.38 The Trust provided evidence dated October 2018 about their 'Reducing Restrictive Interventions' (RRI) training programme (see Appendix H for further details of the programme and of the Trust's RRI Action Plan). All inpatient staff are required to complete the 'Preventing and Managing Violence and Aggression' (PMVA): compliance with this training was 80%, with proposals to ensure that teams below the 85% target take steps to achieve it. The Trust also provides Disengagement and Conflict Resolution training for all clinical staff working in the community: compliance with this training is 85% across the Trust.

9.7.39 Evaluation of the Disengagement and Conflict Resolution training is underway and evaluation of the PMVA training is scheduled for December 2019. The Trust's RRI plan include measures to evidence that work is being undertaken to

[26] The Organisational Development Practitioners (ODPs) – interventions offered by this service (undated).
[27] The Trust informed us that the content of TDDs is locally driven so the centre would not impose a focus on the Thematic Homicide Review on teams.

reduce RIs and is having an impact on service users, carers/families and on staff. This work is complemented by the Trust's involvement in regional and national initiatives and by their planned Patient Safety Collaborative for Acute Inpatient Services (further details in paras 10.17 and 10.18), and the two Psychiatric Intensive Care Unit (PICU) wards are part of a national QI project aimed at reducing the use of RIs[28]. As a result of their involvement in this QI project, the two wards reported they had achieved the following (at May 2019):

- a significant reduction in the use of RI, seclusion and rapid tranquilisation
- increased awareness across their teams on restrictive interventions
- one ward is organising 'bitesize' sessions with the PMVA team in order to provide further training on de-escalation and improving staff confidence
- all blanket bans (for example, on mobile 'phones, belts) have been removed
- improved staff retention
- support to acute wards on referral processes by carrying out and offering face-to-face assessments
- a more collaborative working culture between both PICUs.

This provides a clear example of incorporating training into a wider project.

9.7.40 The Quality and Patient Safety Report for Quarter 4 (Q4) of 2018/19 (January to March 2019) illustrates any changes in the level of incidents and use of RIs, comparing data for Q4 for 2018/19 with Q4 for 2017/18. This shows that:

- The number of seclusion incidents had gone down.
- The length of time people were kept in seclusion had gone down.
- The number of physical restraint incidents had gone down.
- The number of rapid tranquillisation incidents had gone up.
- The number of violence and aggression incidents had gone down.

9.7.41 This indicates that the various initiatives, including training, which the Trust has engaged in has had an impact on reducing RIs (and the situations that give rise to RIs).

9.7.42 The report identified that lower levels of violence and aggression were being reported on the dementia care wards which indicated that the Trust's Bespoke Dementia Care training may be having an impact on helping to reduce levels of distress for people in these services.

9.7.43 Also in this report, data from evaluations of participants in five 'Patient Safety Events – Learning and Improvement' indicated that the great majority were confident or very confident that the training would improve patient safety; and that the great majority thought that the training was relevant or very relevant to

[28] This is taking place under the umbrella of the 'Mental Health Safety Improvement Programme's Reducing Restrictive Practice Collaborative'. They are two of 42 wards taking part across the country. The aim of the project is to reduce restrictive interventions by 50%, replacing them with a culture of positive therapeutic engagement. The PICUs involvement commenced in November 2018 and will be completed in April 2020. This fits into the RRI Action Plan's intention to reduce the use of seclusion, rapid tranquillisation and physical interventions.

their job (see also paras. 9.2.8, 9.2.9 and 9.2.10). A formal evaluation of the Bespoke Dementia Care training was due to be completed in June 2019.

9.7.44 The Trust provided the programme and the staff evaluations for a day conference on Acute Care. The evaluation data demonstrated that staff were from the main clinical professions, ranging from HCAs to senior nurses/directors. All thought the conference was 'relevant' or 'very relevant' to their role, seven sessions were evaluated – for four of these, all respondents thought the session was either 'excellent' or 'good'; for three sessions, the great majority thought the session was either 'excellent' or 'good'. Overall, therefore, the feedback was very positive.

9.7.45 The newly ratified policy on 'missed appointments and engagement' had been influenced by the learning from DNAs and how this has influenced the newly ratified policy and the implementation of the policy will be supported by learning events (further details in para. 9.3.10).

9.7.46 We were provided with a progress report (July 2019) on the project to provide face-to-face clinical risk training (see Appendix H for details). The Lead Clinician for Clinical Risk has developed bespoke training for teams, along with experts from the CDSs, and bespoke 'bitesize training' on care planning and crisis and contingency planning. All training packages are designed in line with actions from serious incident outcomes (see also paras 9.2.22 and 9.4.6).

9.7.47 An evaluation of the clinical risk training (January to June 2019) was provided. Of 232 learners who completed the evaluation forms, the great majority considered that the training was 'relevant' or 'very relevant' to their job; the great majority were either 'confident' or 'very confident' that the training would help improve patient safety and all but one would recommend the training to a colleague. For all the subject sessions, again the great majority of respondents found the training 'useful' or 'very useful'.

9.7.48 We commend the Trust for its commitment to and investment in this face-to-face training; and we support the Trust's plans to agree funding for a permanent post. We would support the Trust in continuing this approach to training in clinical risk, care planning and crisis and contingency planning, and suggest that the Trust considers extending it, where appropriate, to other patient safety issues; and links the training with the QI and OD programmes. In terms of the Kirkpatrick levels, this evidence shows that the Trust is providing training that is positively evaluated in terms of experience and learning.

9.7.49 We were provided with evaluations for additional 'Patient Safety Events – Learning and Improvement' (see Appendix H for details). These events are clearly highly valued in terms of relevance, improving confidence, the quality of the training and willingness to recommend the training to a colleague. This demonstrates that respondents are, on the whole, finding the experience positive; and is indicative of real learning. This form of evaluation cannot incorporate changes to practice or achievement of organisational goals but does suggest that the conditions for changing practice (i.e., attending, enjoying and learning from training events) are in place.

9.7.50 The Trust organised a 'Learning from Serious Incidents' Conference in September 2018 (see Appendix H for details). The evaluation forms only included the questions about rating the quality of the sessions. The vast majority of those who completed the evaluation form rated the sessions as either 'excellent' or 'good'. Written comments were positive about the content, particularly the carer's story presentation and other aspects of the sessions. Negative comments were about practical and technical aspects – presentation slides shown too quickly, print too small to read, difficulty in hearing speakers, and problems parking. As before, the experience and learning were rated positively overall. The conditions for impact of learning on practice and organisational goals are clearly present as a result of this conference.

9.7.51 There is also significant training provided to teams about the Triangle of Care and involving family and friend carers in both care for individuals and in developing care and services within the organisation, with some strong anecdotal evidence that this training is making a difference to the carer experience.

Conclusions

9.7.52 The Trust had done some excellent work in relation to evaluating the impact of its training and development on care and service delivery.

9.7.53 The pilot evaluation of the clinical risk e-learning package, to Kirkpatrick levels 1 and 2 was thorough and detailed, although with a small sample of respondents. We commend the Trust for carrying out this pilot study and would encourage the Trust to follow through on the recommendations to continue to develop ways of evaluating the impact of training and other learning and development activities.

9.7.54 The risk assessment audit identified areas where CDSs were not compliant with standards and accompanying actions to mitigate risk and improve quality of care and address themes arising from the Thematic Homicide Review. This is an excellent example of evaluating the impact of training on practice and revising standards in light of this. As originally planned, re-audit should be carried out when teams have had time to implement the revised standards in practice. The use of audit to link training and practice followed by actions to improve identified areas of non-compliance with standards should be applied more extensively across the Trust.

9.7.55 Additional examples of evaluating training and other learning activities, include the RRI work, face-to-face clinical risk and care planning, an acute care conference, patient safety events – learning and improvement, learning from serious incidents conference.

9.7.56 Feedback from staff on implementing learning from training and other development activities is included in supervision and appraisal – and these are the Trust's focus for embedding learning. We recognise the benefits of focussing on appraisal and supervision as a route for embedding the learning into practice, and note that the Trust has commenced compliance reporting to

the ECAT as a routine agenda item. We would encourage the Trust to build on this to include reporting on implementation of learning into practice in an aggregated format, if the recording system allows this.

9.7.57 On the basis of the evidence we have seen, we consider that there could be more systematic methods for the Trust to understand the 'added value' that resources put into education and training bring to the Trust's activities.

9.7.58 We do appreciate that more extensive and formal evaluations will have resource implications which presents challenges for the Trust. One route for extending evaluation is identified in the pilot evaluation of clinical risk e-learning, where the report authors recommend that the Trust, working with academic partners, encourage staff who are undertaking Master's level education to lead on evaluations of the impact of training (as in the Kirkpatrick model). This approach, along with others, has been used elsewhere to evaluate training using the Kirkpatrick model in full[29, 30, 31].

9.7.59 However, we do recognise that the Trust is putting significant resources into alternative learning and development opportunities such as the OD programme; the QI programme, the Safety Collaboratives, the RRI training and Action Plan and the TDDs.

9.7.60 The initiatives described above represent a Trust-wide approach to evaluating the experience and learning from training and education activities. The evaluations clearly demonstrate that staff value these events positively, and the Trust has provided extensive evidence that they are creating the conditions (attendance, positive experience, relevance and confidence, learning) for training and education to have a positive impact on practice and on the organisation's goals. For the RRI training, the Trust has provided evidence that this has impacted positively on practice and on achieving organisational goals. For the clinical risk e-learning, the audit published in March 2018 showed limited correlations at local service level between completion of the training and completion of risk assessment and management plans (but the evaluation of the face-to-face training would suggest that this may be more effective in impacting on practice). We would encourage the Trust to consider extending these forms of evaluation to additional training and learning activities.

Recommendation 7 implemented at Level 3

[29] Doctoral dissertation evaluating training in the hospitality industry (Florida International University)
[30] Article evaluating health and safety training
[31] Kirkpatrick model used to evaluate training in the US army

9.8 Recommendation 8

"The Trust should continue to act on its commitment to implementing the 'Triangle of Care' approach to involving carers in the care and treatment of service users. The Trust should aim to achieve membership of the national programme within 12 months."

Background to this recommendation

9.8.1 A recurring theme identified in the Thematic Homicide Review was the limited involvement of family members in the care and treatment of service users, provided the service user gave consent. The Trust was already implementing the principles of the Triangle of Care (ToC) in some services. The ToC is a nationally recognised systematic approach to engaging and supporting carers and families of mental health service users[32].

The Trust's approach to the recommendation

9.8.2 The Trust approached the implementation of this recommendation through eight actions, as follows:

a) Recruit Carers Lead to support and drive through improvements for carers (including Triangle of Care).
b) Review progress with Triangle of Care and other relevant programmes that promote effective carer involvement and improve experiences.
c) Work with families involved in past SI cases; carers, patients, staff and partners, to examine the improvement opportunities that can be delivered to meet the needs of carers in all services and create transformational change into the clinical practice of everyday care.
d) In addition to the broad stakeholder involvement, the Trust will develop a specific work stream with its own set of KPIs (co designed with patients and carers) around improving engagement and involvement of carers and service users.
e) Develop 'ten must dos' that will occur in every service with regards to exploring the carers input and engagement with the recovery of the patient.
f) Identifying and assessing carers' needs document from NHS England and scope out the feasibility of the Trust leading the STP in this area to develop

[32] The Triangle of Care is a "therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing." Carers Included: A Guide to Best Practice An application for membership must be signed off by a strategic lead and have carer partners identified. By signing the form an organisation commits to self-assess and embed the Triangle of Care in all their services. Stage one submission must include self-assessment of a minimum of 80% of in-patient services and crisis services, within 12 months of joining; and complete self-assessment of all remaining services and must be completed in no more than two years of submitting stage one. (ToC does not cover CAMHS services). The ToC has six standards, which Trusts are required to attain:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information, are in place.
4) Defined post(s) responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available.

the memorandum of understanding about the very key issues which should always occur for carers and the transfer of information as patients transition services etc.

g) Carers rights day, a suite of activities planned for 25 November 2017.
h) The trust will introduce formal Family Liaison and Support for people affected by Level 2 serious incidents. This will focus on families/carers whose family member has died as a result of an unexpected death while receiving inpatient care or as a result of a homicide.

9.8.3 The Trust has provided extensive and detailed evidence for having implemented this recommendation, through its eight actions.

Definition

9.8.4 The Trust has agreed the use of the term 'family and friend carers' to distinguish this group of people from paid carers or volunteers provided through formal organisational processes.

Membership of the Triangle of Care

9.8.5 The Trust signed up to and was accepted as a member of ToC in August 2017. Three local carer support voluntary organisations are the Trust's strategic partners – Carers Support (West Sussex); Care for the Carers (East Sussex) and Carers Centre (Brighton and Hove).

9.8.6 In October 2017, the ToC was launched to the Trust through a briefing from the CEO. This included three short videos promoting ToC from the perspective of a carer, a service user and a mental healthcare profession. The briefing includes a presentation by Kent and Medway NHS and Social Care Partnership Trust entitled 'Sharing our ToC Journey' to share good practice. This briefing demonstrates the CEO's commitment to promoting and implementing ToC across the Trust.

9.8.7 The CEO also published a statement in Worthing Rethink Newsletter (November 2018) reporting on the Trust's work on ToC and thanking everyone for 'help in moving this forward across the Trust'.

Stage one application

9.8.8 A paper submitted to the Trust Board in May 2017 contained the project plan for ToC in detail up to stage one submission. They will follow the same process to achieve stage two.

9.8.9 Following acceptance as members, the Trust submitted their self-assessment information for stage one in September 2018: in July 2019, the external review panel awarded accreditation status for stage one.

9.8.10 The CEO prepared a video[33] for the external reviewers who attended the Trust for their stage one accreditation. In this video, the CEO emphasised the Trust-wide Carer Leader's calibre, experience and values, and her leadership around how they had been implementing ToC.

9.8.11 The CEO wants ToC to be part of the fabric of delivering recovery-oriented care. She acknowledged that family and friend carers play 'a huge role in the lives of the people we are here to support'. As well as identifying and recognising family and friend carers, the Trust is also supporting and listening to them, and creating a therapeutic alliance between service users, staff and family and friend carers.

9.8.12 The CEO stated that Trust is reviewing its organisational strategy. ToC will be at the centre of that strategy; they are putting family and friend carers alongside service users and staff really working together.

9.8.13 The chair of the panel (interim lead for ToC for the Carers Trust) said:

> 'I am astounded by the work that Sussex has done in their first stage of Triangle of Care. It is evident that there is buy in from all levels of the Trust and that the Trust has embraced Triangle of Care in an exceptional way. Their information and involvement is of note and Carers are clearly involved in the development of services and throughout the organisation. I applaud the work done and want to congratulate the Trust in their achievements'[34].

9.8.14 The Director for England at Carers Trust stated:

> 'The work that Sussex Partnership NHS Foundation Trust has shown how the Triangle of Care can improve the lives of carers of people with Mental Health Conditions. The Trust has gone above and beyond what is expected and their work is of an exceptional standard. They clearly include carers in the development of their ongoing work and it is evident that the Triangle of Care is embedded throughout all levels in the Trust'.

9.8.15 In May 2019, 97% of in-patient services (71 in-patient teams, excluding CAMHS) had completed the stage one self-assessment, so the Trust has now achieved well in excess of the national target (80%).

9.8.16 The Trust is working to submit self-assessment for all 200 community teams by the end of 2019.

Recruitment of Carer Leader

9.8.17 The Trust appointed a Trust-wide Carer Leader (herself a carer, working 2.5 days a week) in October 2016. In response to a question we asked about the support the Trust-wide Carer Leader had received, she said that, when first appointed the support provided had been insufficient, but that this had since improved and she now has a full-time business and project manager.

[33] CEO video
[34] Sussex partnership press release, 8 July 2019

9.8.18 The Trust-wide Carer Leader is now chair of the ToC Advisory Group: the Vice-Chair was the Chief Nurse until March 2019, when she stood down from the Group and was replaced by the Associate Director of People Participation, who reports to the Chief Nurse. The Chief Nurse is also a member of the Trust Board and the Executive Management Committee.

9.8.19 The Trust-wide Carer Leader has been proactively progressing both the formal ToC process (self-assessments for stages one and two) and a wide range of carer involvement and support activities across the Trust, and in staff training, again across the Trust (see Appendix I for details). The Trust-wide Carer Leader led carer awareness training for staff. In July 2018, 10% of staff had been trained, with priority given initially to the 'stage one services'.

9.8.20 Carer awareness training, with carer involvement, continues with multi-disciplinary teams – 'typically' the training is rated overall as 9/10; and 100% of participants would recommend it to others.

9.8.21 Although this has not been designated mandatory training (as stated in the '10 must-dos'), the CEO is encouraging TDDs which will include this training. Those who have received the training are expected then to train their colleagues.

9.8.22 Carer support leads have been appointed in Langley Green and Meadowfield hospitals and in the forensic healthcare service. Recent appointments of two full-time carer support roles have been made in Hastings and Eastbourne urgent care teams.

9.8.23 The Trust-wide Carer Leader attended a 'stakeholder workshop' for the Sussex and East Surrey STP – 'Together for Carers' (October 2018). The workshop included hearing about key national developments; exchanging information about local developments; and discussing some priorities for work across the STP to improve support for carers. She found this useful in meeting colleagues from other agencies and understanding the bigger picture.

9.8.24 The Trust-wide Carer Leader was nominated for two 'Positive Practice' Trust awards in November 2018.

9.8.25 There is a strong commitment from the Board, especially the Trust CEO and Chief Nurse. For Carers Week 2019, the Trust-wide Carer Leader with the CEO of a carer support partner agency and a carer gave a presentation to the Board. This was well received – the Board said it brought the Triangle of Care and carer involvement to life for them.

Review progress of ToC and other carer involvement activities

9.8.26 The Trust has established a Trust-wide Triangle of Care Advisory Group. The purpose of this Group is to 'maintain membership of the ToC through working with family and friend carer organisations and people they represent to embed the ToC standards across the Trust' and to 'review the progress of ToC'. The Terms of Reference were approved at the Group's first meeting in November 2017. This Group reports to the Positive Experience Committee, which in turn

reports to the Quality Committee and finally an assurance report goes to the Trust Board.

9.8.27 The Group brings together all the Trust's ToC activities, with membership from a range of Trust services. All relevant CDSs are represented; the professions of nursing, occupational therapy, psychology and social work are represented; and the Trust's strategic partners in implementing the ToC (local carer support organisations). We reviewed the minutes of the Group's meetings held in November 2017, in March, June, September, December 2018 and in March 2019.

9.8.28 The Trust-wide Carer Leader reported that attendance at the meetings is very good, very senior people attend, there is a lot of energy, commitment and goodwill, and it has been a good platform for sharing learning, embedding the ToC and developing practice.

9.8.29 Minutes of the Group (see Appendix I for details) reported on:

- changes to Carenotes to improve recording of carer information, and a training video for staff
- introduction of a new form for recording service user consent to staff sharing information with carers, which adds an option for partial sharing of information
- a Carers' pack that had been developed for use in the West Sussex CDS, which had been well received by carers
- carer surgeries held by the Bognor and Chichester Assessment and Treatment Service; and two full-time carer assessment workers at Mill View Hospital who are seconded into the Trust and will cover both inpatient and community services, focussing on 'reviews and carer assessments'
- a QI project to improve carer support and involvement with one community team, with findings about early listening to carers who sometimes felt 'on the fringe of' care for their relative/friend, that patients are 'falling through the cracks' and the team's plans to improve engagement of carers and support for them
- Carers Rights Day and Carers Week activities.

9.8.30 The ToC Advisory Group also monitored progress on stage one self-assessment.

9.8.31 The Trust has approved a revised 'Carers and Confidentiality' policy and produced guidance for staff and carers. The key point is that it does not breach confidentiality to 'simply talk and listen to a carer, to find out what they know about the service user, provide information about their rights, and the support available, and factual information in general about a mental health problem'. Confusion on the first point, that staff cannot listen to what carers have to say about a service user, has arisen as a theme in investigations into treatment and care of someone when things have gone very wrong and we welcome the Trust's new policy which explicitly states the correct position.

9.8.32 There is anecdotal evidence that the experience of family and friend carers has improved since the Thematic Homicide Review was published. The 'Family Story' item at the Trust Board meeting in March 2018, when the parents of a daughter who had died whilst in the care of the Trust, is particularly pertinent. They told how their perception of the Trust had changed from it being experienced as obstructive and negative to the Trust 'really changing' so that they are 'happy to support the Trust' in the future. This powerfully illustrates how the Trust's attitudes and support to carers had improved over the previous year. The CEO had allowed them to re-write the serious incident report; and they had told their story to 200 staff at a recent conference.

9.8.33 A report on the Carers Rights Day event at one hospital in 2016 indicated that carers found they were made to feel 'so welcome', they really felt that things are going to change for the better, sharing stories, pledges from the care team for improvement and involvement of users.

9.8.34 Referrals by Trust staff of carers to carer support agencies have increased (West Sussex by 54%; East Sussex from 1 to 60 referrals; Brighton and Hove Hub by 18%), as reported to the Group meeting, September 2018. In December 2018, there was a discussion of the increase in demand from mental health carers to the partner agencies.

9.8.35 In March 2018, in relation to Hasting and North West Sussex, it was reported that progress of implementing ToC in community teams was slow, because of pressures of work and staff working away from the office. The Trust is providing support, link workers and quality improvement projects involving families. However, we do recognise that it can be more complex to progress ToC in community services as the work context is more dispersed.

9.8.36 Care teams report their work in relation to ToC and family and friend carer involvement through the relevant CDS, which is part of the internal governance process.

9.8.37 The Sussex Recovery College (supported by the Trust) offers a range of training courses for service users, carers and staff. All training is co-facilitated by a mental health care practitioner and a peer trainer – service users where the course is specific to understanding and living with mental health challenges and to developing their wellbeing, and carers where the course is specific to supporting carers. A course for 'Experts by Experience' is also available, who can attend to refresh their knowledge of techniques and information to help them get involved effectively in service improvement at the Trust.

9.8.38 Evidence was also provided for the involvement of one of the Trust's Experts by Experience in the delivery of a day conference in November 2018 on the value that administrative staff contribute to the delivery of services.

9.8.39 We note that the 'Integrated clinical risk and care plan clinical audit' (March 2018), revealed a lack of evidence for involving service users and carers in clinical risk, crisis and care planning. The audit report included mitigating actions after having identified this area for improving involving carers and service users, as follows:

- ToC training to staff.
- QI work in relation to working with carers and sharing the risk plans with service users and carers.
- We note that a service user and a carer consultant sit as full members on ECAT. Family and friend carers and service users are also members of CAGS – there are 41 groups of which 15 included carers and service users as members.
- As part of the suicide prevention strategy, suicide prevention training has been developed which is co-produced and delivered with carers and services users.
- The Trust has created 'Working Together' groups across the Trust in both in-patient and community settings – for service users and carers to have a say on services provided by the organisation and to have their say in decision-making. Each group is committed to working on a QI project to ensure they are actively involved. There are plans to increase the amount of QI work that is led by service users and carers.
- A carer peer support worker role (an employee of the Trust) is being developed. Two have recently been appointed in Hastings and Eastbourne urgent care teams.
- For staff who are also carers, the Trust-wide Carer Leader and HR Director are developing a wellbeing programme for staff generally and there is a poster available in all work areas inviting anyone who supports a family or friend who is accessing Trust services to make contact. New staff are made aware of the Trust's support for family and friend carers at induction as part of a wellbeing pack. The Trust is working on supporting their staff who are family and friend carers outside work.

Support to families involved in Level 2 serious incidents

9.8.40 The Trust provided a range of evidence on supporting and involving families and carers following serious incidents and through serious incident investigations.

9.8.41 The Trust's policy on 'Incidents, Serious Incidents and Learning from Deaths' (May 2017) includes a very clear statement as to the centrality of families and carers in responding to and investigating serious incidents.

9.8.42 The Trust's Duty of Candour policy and policy on a page, and Duty of Candour leaflet include a reference to the centrality of families following serious incidents. The Trust created the role of Family Liaison Leads, to support families and carers Including close friends where relevant) through the process of a serious incident investigation. A Family Liaison Lead will work with families/carers for investigations into an inpatient death, a mental health-related homicide or the death of people whose care was very complex. They will be the first point of contact for family/carers from the beginning of the investigation up to its conclusion (which may include a Coroner's Inquest). Minutes of Safety Committee and a Safety Committee exception report to the Quality Committee demonstrate that a carer and a service user are members of the Safety Committee.

9.8.43 There is 'Learning from Deaths[35]' guidance on how to involve and support families which is incorporated into the serious incident process. The guidance sets out principles of the support to bereaved families and carers, with emphasis on their rights and what they can expect from the Trust.

9.8.44 The Trust was cited as an exemplar:

> 'Sussex Partnership NHS Foundation Trust was rated as good overall in January 2018. The trust was one of the first in England to be involved with Making Families Count, an approach developed by the charity 100Families and NHS England. Through this work, the trust was one of the first in the country to implement a team of dedicated family liaison leads, which was introduced in August 2016. This team led on the investigation of serious incidents and worked with bereaved families during the process of investigating the death of their family members. There were three dedicated family liaison leads, with a further 13 staff trained to provide family liaison services. The family liaison leads were part of the serious incident team and provided root cause analysis training to senior staff who carried out reviews, which were based on a strong ethos of enabling strong engagement with families and carers. This included, as part of serious incident reports, details of family meetings and the views of the family, as well as ensuring that duty of candour requirements had been met.'

9.8.45 In addition, the Trust held a conference on 'Learning from Serious Incidents' in September 2018. This included a presentation (My Story) from a carer, and a presentation by the Chief Nurse on the importance of involving families.

9.8.46 The root cause analysis training also includes sessions on Duty of Candour and family involvement in investigations.

Trust's Key Performance Indicators and '10 Must Dos'

9.8.47 To implement both these actions, the Trust developed '10 must dos' at a Hackathon held with carers in December 2016. In May 2017, an assurance report to the Trust Board noted that there was overlap with the work being carried out in relation to the ToC and the six ToC standards and incorporated these together.

9.8.48 The '10 must dos' were updated (July 2018) – these items were all being carried forward through the ToC programme.

9.8.49 Carer support organisations were approached to work in partnership to bid for 'carer peer support workers' funding but reported that they needed more time to consider the proposals. The Trust was revisiting this (July 2018, 10 must dos update), and looking for how they can link in with local carer support organisations.

[35] National Quality Board (July 2018) 'Learning from deaths. Guidance for NHS trusts on working with bereaved families and carers'

9.8.50 The report on the ToC 'one year on' also demonstrates the progress the Trust is making. Progress on the '10 must dos' is covered by progress on implementing the TOC.

Feasibility of the Trust leading the STP to develop a memorandum of understanding about the key issues for carers and transfer of information

9.8.51 The Trust completed work with NHS England which concluded that any further developments would be carried out by the CCGs. Consequently, the Trust took no further action in this respect.

Carers rights days.

9.8.52 Events have been put on by various Trust services to support the annual Carers UK 'Carers Day' in 2016, 2017, 2018 and 2019. The aims of these days are to: 'raise awareness of the needs of carers'; 'make carers aware of their rights'; and 'let carers know where to get help and support'.

9.8.53 The Trust holds its own events under the Carers UK banner. Services are encouraged through the ToC Advisory Group to hold activities on these days. These events included information sessions for carers and 'tea/coffee and cake' with information and support available. The 'carers day' activities are promoted by means of tweets, emails, the Trust website and videos.

Conclusions

9.8.54 The Trust has demonstrated its commitment to ToC at the highest level of the organisation. It has made significant strides in the support provided to and involvement offered to carers since 2016, in which the Trust-wide Carer Leader has played a major part. We welcome the CEO's commitment that ToC will remain a key component of the Trust's strategy. The Trust-wide Carer Leader has made a critical contribution to the progress the Trust has made. The current level and grade of support, and resources for this work need to remain solely focussed on ToC implementation.

9.8.55 The Trust has fully implemented the specific element of Recommendation 8, that the Trust 'aim to achieve membership of the national programme [ToC] within 12 months'. The Trust is clearly continuing to act on its commitment to implementing the Triangle of Care approach to involving carers in the care and treatment of service users. We fully commend the Trust's impressive work towards achieving full ToC accreditation.

Recommendation 8. Implemented at Level 3.

10 Quality Improvement in the Trust

10.1 Although QI was not included in our original recommendations, it had clearly become a significant element in the Trust's approach to improving services, care and treatment, so we decided it was important to include QI in our review and to recognise the work the Trust is doing.

10.2 The QI programme has been running in the Trust since 2017, when the current Assistant Director (then a new post) joined from East London NHS Foundation Trust (the location for a case study in the King's Fund report[36]). He has been building the Trust's capacity to implement QI. The programme is for seven years, they are two years into it. It is Trust funded with CQC support and the QI programme is focussing on co-produced services.

10.3 This model for improvement poses three questions:

- What are we having to change?
- What does improvement look like?
- How to do it?

10.4 Using the 'Plan, Do, Study, Act' model in all the second wave projects, they are asking, 'How good by when?' as their approach to measuring impact.

10.5 All the Trust's 'traffic light' data is moving to evaluation by means of the Statistical Process Control model. The Trust is seen as an early adopter by NHSI and their approach is completely aligned to the NHSI process.

10.6 The QI team informed us that they wanted all staff to have completed the online QI Bronze level training. The number at the time of the interview was 473. They hope many staff as possible will complete their face-to-face QI Silver training. This two-day skills-based classroom training was launched in September 2018, runs approximately every month and is designed for all staff. In June 2019, 286 people had attended Silver training across a range of geographical locations, including Board level Directors, carers, service users and a range of staff of all bands and backgrounds. One of the main purposes of the Silver training is to equip individuals to lead or sponsor a QI project.

10.7 Training must be accessible and meaningful. The Improvement Academy is trying to reach out to several Trusts with something that could be done online and reach the whole workforce – giving them the freedom to get involved. The Silver is to enable people to lead projects. It is a two-day four-module programme, with a focus on designing and delivering projects.

10.8 The training is experiential so it is accessible, regardless of academic background. The feedback has been very good. It is clear from self-assessment that the training increases learners' confidence, and they develop coaching rapport from the project work.

[36] Ross, S. and Naylor, C. (2017) 'Quality improvement in mental health' The Kings Fund, London

10.9 The training focusses on how a “Sussex” project works, with a focus on ToC, patient-centred care and clinical practice. The Trust are developing co-produced services, working to find solutions with service user, carer and professional perspectives.

10.10 The QI team have facilitated several inpatient and community ward/team away days at which they have engaged staff with QI methods and tools to enable learning and development.

10.11 QI is not just about projects, it’s about energising the people nearest to the problem. Before the Trust introduced QI, the organisation was trying to transition from a performance, target-driven culture towards a learning culture. The QI approach values and appreciates staff, so they are working to energise the whole workforce, getting people into the improvement way of working.

10.12 The projects are self-determined – people work on areas of high value to themselves. A project starts with a workshop on a self-assessment of the services, their description of themselves. The QI team asks for their priority areas, then develop a QI project to feed into service priorities.

10.13 Having the Trust Board involved is crucial, the team could not implement QI without their commitment. QI needs all levels of the organisation to be working this way. Having the Executive Directors as sponsors is also important because it means they are working with people at the front line.

10.14 The Board is one of 10 NHS trust boards nationally which are undertaking the NHSI ‘Building Leadership for Improvement Programme’. This programme lasts a year and the aim is to build Board level capability for QI. The Chief Medical Officer, COO and Chief Nurse are also undertaking the IHI’s Executive Development Programme this year.

10.15 Each project has a lead (Bronze level trained), a sponsor (Silver level trained) and a coach (Gold level trained).

10.16 Examples of QI projects in inpatient services include work on supervision standards and risk assessment. Experts by Experience are leading another project for patients to develop a journal through their inpatient stay which will lead to a more focussed way of doing person-centred care. Service users are leading it with the right support, to see how it develops. Other examples include a QI project on the quality of information, care planning and risk assessment. The QI work will continue to work on improving compliance in risk assessment, focussing on the quality of both risk assessments and care plans in clinical practice. This will also help the Trust identify what further help is required and how the Trust can support staff.

10.17 The Trust is an active participant in the Mental Health Safety Collaborative[37] on reducing the use of restrictive practices (for both PICUs) and is an active member of the South Mental Health Improvement Collaborative[38].

10.18 Led by the Chief Nurse, the Trust has just launched its own Patient Safety Collaborative for Acute Inpatient Wards (at the Acute Care Conference, July 2019) with a day event planned for late August 2019. This Collaborative includes sharing good practice around reducing restrictive interventions.

10.19 The Trust has also introduced 'excellence reporting'[39] as part of its online incident reporting system. The most recent Quality and Patient Safety Report shows that the system was launched in January 2019: by the end of March 2019, 38 excellence reports had been submitted, originating from six of the seven CDSs. Themes are identified, for example, the themes with most reports are:

- 'going the extra mile'
- episode of care that went well.

This is a new initiative and the Trust has demonstrated that it is monitoring and reporting progress to the Quality Committee, and thence to the Board.

10.20 The July Patient Safety Matters (in the final editing stage, at the time of writing) will focus on compassionate care and 'excellence reporting'.

10.21 The culture of the organisation is critical – the Trust is looking at improvement, learning and changes to practice through the use of QI projects, and learning from them, rather than just relying on systems and processes.

Conclusions

10.22 We were impressed by the Trust's commitment to using QI as a tool for organisational and cultural change, and by the enthusiasm and knowledge shown by the two members of the QI team whom we spoke to. We note that this model is aligned to the Triangle of Care, to their focus on person-centred care and to their OD programme. The QI approach is also fully aligned with the Trust's focus on improving patient safety. We appreciate that it is relatively early days for this initiative, and that staff continue to be trained, to complete

[37] The Reducing Restrictive Practice (RRP) collaborative is part of a wider Mental Health Safety Improvement Programme (MHSIP) which was established by NHS Improvement (NHSI) in partnership with the Care Quality Commission (CQC). The aim of the RRP is to reduce restrictive practice (measured by episodes of restraints, seclusions and rapid tranquilisations) by 33% in the wards that are selected to take part. The programme will work to design the programme in collaboration with experts and experts by experience; provide tools and resources for selected wards to develop their own quality improvement plans; support wards to carry out quality improvement through bimonthly learning days and dedicated Quality Improvement Coaches (Improving care - reducing restrictive practices)

[38] The South of England Mental Health Quality and Patient Safety Improvement Collaborative is funded and supported by the West of England and the South West Academic Health Science Networks. Eleven mental health trusts in the South of England make up its membership. The Collaborative empowers people with lived experience and healthcare staff to work together to identify and develop solutions to local problems. It supports individuals, teams and organisations to build skills and knowledge about quality and safety improvement, creates space and time to work on safety issues, and provides opportunities to continually learn from each other.

[39] The focus of excellence reporting is to report and recognise excellent practice in healthcare - studying excellence in healthcare can create new opportunities for learning and improving patient safety. The 'Learning from Excellence' website has been capturing and studying peer-reported excellence in healthcare since 2014. This site is a source of open-access resources and ideas to promote this initiative and share experiences. This focus on excellence is intended to 'redress the balance' away from the traditional focus on avoiding harm by learning from error". Source: Learning from Excellence

existing projects and to develop new ones. We fully commend the Trust for its commitment to and investment in these developments.

11 Review of Clinical Commissioning Groups' monitoring of serious incident action plans

Context for this review

11.1 The Terms of Reference for this quality assurance review includes:

> "The assurance review should identify whether the Trust and CCGs governance structures continue to provide effective reporting, monitoring and learning from serious incidents in line with the NHS England Serious Incident Framework – Supporting Learning to Prevent Recurrence and subsequent policy and organisational development."

11.2 The Trust's governance structures have been addressed in relation to Recommendation 2 (this report, pages 31-38). This section will review the relevant CCGs' governance structures.

11.3 There have been significant changes in the configuration of CCGs[40] since the Thematic Homicide Review was published in 2016, and there are plans for the Sussex component of the current Sustainability and Transformation Partnership to become an Integrated Care System[41]. Key personnel in the CCGs have remained involved in monitoring serious incidents and their action plans, so providing some continuity. The Brighton and Hove CCG provides the CCG lead for quality in respect of the Trust – their Head of Quality is also Head of Quality at the commissioning CCG.

11.4 The CCG which was responsible in 2016 for monitoring the action plan arising from the Thematic Homicide Review and its implementation no longer has this responsibility. We had planned to obtain evidence from this CCG about its monitoring of the Trust's progress in implementing the action plan in the form of minutes of their contract monitoring meetings with the Trust, but no information was available, therefore we could not review this.

[40] There are eight CCGs commissioning services across Sussex and East Surrey. The CCG Quality Directorate is now one team across the eight Sussex and East Surrey (SES) CCGs. There is a Chief Nurse with executive responsibility for quality and patient safety. Reporting to the Chief Nurse is a Deputy Director for Quality and Patient Safety who is responsible for management of the CCG Patient Safety Team (a hosted service within Brighton and Hove CCG) that manages SIs for commissioned providers on behalf of the eight CCGs. The eight CCGs are led by a single Chief Executive. There is a proposal to move to three CCGs which will be coterminous with local authorities. This will facilitate more effective joint working between health and social care providers. At the time of the Thematic Homicide Review, the lead CCG for commissioning services from the Trust was Coastal West Sussex: in 2018 the contract moved to High Weald Lewes Havens CCG. All SIs that happen in services commissioned by each CCG are reported to and monitored by that CCG.

[41] In 2016 the NHS and local councils came together in 44 areas covering all of England to develop new partnerships, known as sustainability and transformation partnerships to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health. There are proposals for the STP to become an integrated care system (ICS). This refers to NHS organisations working with local councils and others (such as local charities and community groups), take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Local services can provide better and more joined up care for patients when different organisations work together. ICSs can help people to live healthier lives for longer, and to stay out of hospital when they do not need to be there. Integrated Care Systems

11.5 However, we have been provided with information about how current arrangements work and have held discussions with the Head of Quality of Brighton and Hove CCG who is currently the lead for reporting and monitoring learning from serious incidents at the Trust.

Current arrangements for contract and quality monitoring

11.6 The following section summarises commissioners' guidance on reporting and managing incidents and serious incidents.

11.7 The 'Policy and Procedures for Reporting and Managing Incidents and Serious Incidents'[42] document is an amended version of the 2017-2019 policy, amended to align the policy across all the CCGs in the Sussex and East Surrey Sustainability and Transformation Partnership (SES STP). This document sets out the processes and procedures for the reporting and managing all incidents and serious incidents (including near misses), clinical and non-clinical, in relation to the CCG and the services it commissions. The key points are summarised here (see Appendix J for details).

11.8 The policy highlights the need for an open and transparent approach to maximise learning, which avoids blame or staff feeling under threat through incident reporting:

> "The CCG promotes a just, fair and responsible culture that fosters learning and improvement whilst encouraging accountability. … The CCG recognises that a root cause analysis approach to investigating incidents focusses on systems processes and failures that allow errors to happen, and identifies lessons learned to enable improvements to be made that eliminate (or prevent as far as possible) the incident or error from re-occurring.
>
> Staff reporting and involved in incidents …….. will not be subject to disciplinary action or suffer any material loss or disadvantage unless they have been negligent in their acts or omissions or willfully failed to comply with professional standards and codes of practice." (p. 9)

11.9 Incident reporting is a fundamental aspect of risk management – the aim is to collect information about incidents, including near misses, to facilitate wider organisational learning.

11.10 This policy details how to report all incidents and near misses, including serious incidents. It applies to incidents that involve patients, carers, visitors, staff, premises, property, other assets, data, or any other aspect of the organisation in commissioned services.

11.11 All serious incidents are logged on a national database system (STEIS). CCGs are responsible for approving closure of serious incidents occurring in the Trust are managed by the SES STP Patient Safety Team, acting on behalf of all SES

[42] 'Policy and Procedures for Reporting and Managing Incidents and Serious Incidents' v9 Issued 8/10/2018

CCGs. The CCGs and all service providers providing NHS care are expected to comply with NHS England (2015).

Serious Incidents

11.12 In broad terms, serious incidents are events in health care where the consequences for patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that they warrant using additional resources to mount a comprehensive response.

11.13 The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff. Serious incidents, therefore, require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these.

Serious Incident reporting

11.14 The document sets out four stages for reporting a suspected serious incident:

1. Report to the STP Patient Safety Team who decide if the incident meets the criteria for a serious incident.
2. Report onto STEIS database – not later than two working days after the CCG becomes aware of the incident.
3. Investigation of the incident in accordance with NHS England (2015), usually using the root cause analysis method. If a serious incident also involves safeguarding (children and adults at risk) the CCG will work with the local authority to ensure an investigation meets the requirements of both safeguarding and serious incident investigation processes. Investigations are to be completed and submitted to the Patient Safety Team within 60 working days of reporting on STEIS, unless an extension is agreed with the CCG.
4. Closure of incidents and serious incidents – once submitted, the SES Serious Incident Scrutiny Group will approve closure or otherwise of all incidents and serious incidents in services commissioned by the CCG.

11.15 CCGs are to inform NHS England of exceptional serious incidents (including mental-health related homicides). CCGs will also report patient safety incidents to the National Reporting and Learning System[43]. There are different requirements for other types of incidents (for example, information governance). Appendices include forms for reporting incidents and serious incidents, grading the severity of incidents and examples of serious incidents .

11.16 The policy also includes the Terms of Reference for the SES Serious Incident Scrutiny Group. The overall purpose of this Group is to review serious incident investigation reports for NHS providers and independent organisations providing NHS-funded care commissioned by CCGs in the SES STP. The

[43] NRLS shares lessons learnt locally and nationally; and informs the national safety alert system.

group enables individual CCGs to discharge their responsibility for closure of serious incidents as described in NHS England (March 2015).

11.17 The group meets fortnightly, although there may be occasions when an extraordinary meeting may be convened. Membership includes representatives of the STP and some CCGs. The document sets out closure criteria. The key point is that the final report should be 'submitted in a format that can be wholly understood by patients, families and carers'.

11.18 Following SI closure by the scrutiny panel, the relevant CCG is responsible for gaining assurance that action plans have been implemented through quality review meetings with the service provider. The CCG Patient Safety Team is reported to be working well with the Trust's Patient Safety Manager. The Team carry out a first-line review of investigations reports, to ensure the report is ready to go to the Scrutiny Panel. They ask:

a) is it robust and fit for purpose?
b) have they identified a suitable root cause?
c) does the action plan fit the results of the investigation and is it measurable and auditable?

11.19 The STP CCGs Policy and Procedures for Reporting and Managing Incidents and Serious Incidents as relevant to the Trust was presented to the appropriate Quality and Safety Committee on 13 March 2019 for approval. There were no substantive differences from the previous version, although some details had been omitted – this was to be provided before the document could be agreed as a final version.

11.20 The draft Terms of Reference (31 December 2018) for the CCG's Sussex Partnership NHS FT Clinical Quality and Performance Group (SPFT CQPG) highlight its purpose which is to monitor ongoing clinical quality and performance. The monitoring includes consideration of serious incidents requiring investigation – which is a standing item at every meeting. The agenda item is divided into learning, action plans from serious incidents and themes identified from serious incidents .

11.21 The SPFT CQPG is expected to reach agreed positions on the issues it discusses and to make recommendations to the Contract Management Board (CMB) for final sign off. When this does not happen, and if escalation to the CMB is required (without recommendation for sign off), then a briefing paper should be provided to help the CMB to progress to a resolution. The membership of SPFT CQPG includes representatives of commissioners and the Trust: NHS England are members when relevant to the agenda. They meet monthly. This Group reports directly to the CMB.

11.22 The SPFT CQPG meeting in January 2019 noted that membership of this Group was awaiting clarification: this outstanding item was ongoing at the April meeting, the most recent for which we have notes.

Monitoring in practice

11.23The SPFT CQPG determined that they would align their meeting agendas with the Trust's own business cycle. The SPFT CQPG meeting in January 2019 included a report that this was being taken forward, the combined annual cycle of business for 2019/20 demonstrates that this has been planned in detail. This meeting discussed:

- Completion of SI investigations within 60 working days – the Trust are working with CCGs to improve the turnaround. Commissioners require assurance that things are happening in a timely manner. The Trust was to provide a trajectory for when the Trust will achieve threshold and a narrative on exceptions.
- A schedule for quality assurance visits was to be developed.
- The CCG quality assurance manager is to be invited to the Trust's quality and safety reviews.
- The Trust requested further clarity to understand commissioners' expectations for serious incident updates – commissioners asked to be informed about the range of workstreams the Trust have implemented as a result of serious incidents .
- Discussion of compliance with Active Engagement (DNA) policy – a recurrent theme in serious incidents . In March, the action was closed, as a new policy document including learning was to be ratified.
- The new Trust Risk Assessment policy (developed as a result of a theme emerging from serious incident investigations) was noted and its implementation discussed.

11.24Notes of the February meeting of this group included updates on two serious incidents. One concerned an independent quality assurance review of the implementation of an action plan following a serious incident which was progressing. The second was also an independent review which had commenced. The CCG's CQPG in February 2019 noted a comment from the carers group in West Sussex, saying that they do not always feel involved in the development of the care plans with service users (for example, patient granted unaccompanied leave and the carer not informed and they absconded). This would be an item at a future meeting.

11.25The March meeting noted that the Trust had provided the trajectory requested at the January meeting; and that workstreams arising from serious incident investigations had also been provided. These actions were therefore closed.

11.26A Quarterly Quality Report was presented – relevant points included:

- There had been an increase in serious incidents over the previous quarter but numbers were similar to Quarter 3 in the previous year.
- Duty of candour breaches related to there being no next of kin recorded in the clinical records.

11.27The item on serious incident updates included progress reports on the action plan for one serious incident; and a note that no single root cause had been

found for a second. The Chair was to review the process of feedback to the Trust from serious incident panels, and there was an update on the Trust response to recommendations from an independent investigation of a mental health-related homicide.

11.28 We have reviewed the draft notes of the April meeting. It was recorded that:

- CCGs were considering options in relation to improving feedback from Serious Incident Panel to the Trust, either through Trust attendance at Serious Incident Panel or separate monthly feedback meetings after Panel[44].
- An update on the progress of the Thematic Homicide Review Quality Assurance Review – the Trust had submitted all the evidence requested; the review team had arranged interviews with key staff, and attendance at the June meeting of the Trust's Quality Committee.
- Consideration of the Trust's Physical Healthcare Team, issues around physical healthcare being a theme emerging from serious incidents the CCG had reviewed.
- Trust to send their Serious Incident Assurance Report to the Chair following their next Quality Committee meeting.
- In response to a Coroner's report the Trust has responded to Coroner in full and will share the response with the Chair.
- There is another Coroner's report which the Trust will respond to within the next couple of weeks with a copy to the Chair.
- Trust to provide an update on the quality improvement plans in relation to CPA 12-month reviews and clustering at the May meeting.

11.29 For the May meeting of the CQPG the CCG has asked for an update on the Trust is doing around the ToC, as the CCG has noted in serious incidents that families/carers are not always involved in risk assessment/care and treatment planning. In discussion, we noted that, although audit demonstrated compliance with risk assessments overall there are still a number of records which are not compliant and these may be the cases where an incident has occurred.

11.30 Two monthly serious incident reports to the CCG's Quality and Safety Committee were provided.[45]

11.31 In March 2019, the report covered serious incidents reported in December 2018 and January 2019. These SIs cover the whole of the STP and all types of healthcare incident (not just mental health). Data is provided for:

- the number and type of incident for each CCG in the STP
- the total number of serious incidents declared by the provider, including a rating to indicate if the number/types of incidents had increased, remained the same or decreased compared to the previous two months
- investigation completion rates (within 60 working days) by the provider

[44] We have been informed that providers attend for the discussion but leave before decisions are made by the Panel
[45] Quality committees are formal sub-committees of the CCG Governing Bodies – the purpose of these committees is to provide assurance that CCGs are effectively managing provider serious incidents, in terms of robust scrutiny of provider investigation reports, as well as evidencing learning and changes to practice in providers as a result of serious incidents.

- serious incidents that were still open at the end of January 2019, and
- the number of serious incidents reviewed by the Scrutiny Group.

11.32 The report includes a note on quality improvements made as a result of serious incidents – for the Trust, this is a summary of information and actions recorded in the notes of the SPFT CQPG meetings described above.

11.33 The serious incident report submitted to the May Quality and Safety Committee provides data for the same topics (as the March report) about serious incidents reported during January and February 2019.

11.34 Again, the highest number by type of incident reported by the Trust was 'apparent or actual self-harm'. This is in keeping with previous months and is consistently the highest type of serious incident reported. The Trust does have a 'positive' reporting culture in terms of reporting self-harm incidents in addition to completed suicides.

11.35 At the April contract meeting with the Trust it was agreed to have monthly meetings in between Serious Incident Scrutiny Panels to review all overdue serious incident reports, including those kept open by the Scrutiny Panel. The Trust had the highest number of overdue reports in this report.

11.36 The section on quality improvement as a result of serious incidents summarises the content of the CQPG meeting notes.

11.37 The CCG requests feedback on whether the report provides sufficient assurance on reporting and management of serious incident for the Committee.

11.38 The CCGs continue to have a focus on ensuring evidence of lessons learned and action plans are embedded in practice, with monitoring as a standard agenda item at monthly quality review group meetings.

11.39 Both reports contain a paragraph on patient and public engagement which indicate that high-level information on serious incidents in made publicly available through reports to trust boards and governing bodies. It notes that CCGs and providers are required to undertake engagement with patients and carers to identify where quality improvements are needed and to inform the commissioning process.

Conclusions

11.40 Overall, we felt that the tone of the SPFT CQPG meetings demonstrated a culture where commissioners and the Trust were working collaboratively to improve quality and safety – both in response to serious incidents and more generally. The CCG has provided clear evidence of effective monitoring of serious incident investigations and action plans. The CCG's approach is consistent with NHS England (2015).

12 Conclusions and next steps.

Overall conclusions

12.1 The Trust Board has achieved Level 3 in respect of Recommendation 1 as it has presented evidence that implementation has been described, documented and is working across the whole organisation. It has built upon its pre-2016 committee and board structure to strengthen its monitoring of the completion and subsequent implementation of action plans derived from serious incident investigations. It has several tiers of oversight which supervise the serious incident process from beginning to end. The various committees and boards have interlocking membership so that detailed knowledge of serious incidents is not restricted to less senior members of staff. Senior members of staff are involved from the very earliest stages of the process through to their conclusion. The Chief Nurse plays a particularly important role as the focus of a number of strands of responsibility for investigating, scrutinising and managing serious incident investigations and implementing action plans.

12.2 Since January 2019, the Central Governance Team has implemented a revised system for monitoring the completion of action plans. Evidence is now reviewed centrally before action plans are closed. The Team assesses the quality of the evidence supporting the completion and will revisit the service six to 12 months later to ensure that the changes have been embedded into practice.

12.3 The Trust Board has achieved Level 3 in respect of Recommendation 2 as it can show that learning from all recommendations in serious incident investigation reports is being fully embedded across the organisation in a timely manner. The Trust has very clearly invested considerable resources into a comprehensive programme of events and activities to embed learning from the Thematic Homicide Review across its workforce. The range of topics covered is extensive, and the approaches taken in spreading these important messages are imaginative. Evaluations have been carried out, and the Trust collects data on the diffusion of training across the organisation. The Trust uses this information at a local level to ensure that learning has been embedded across the organisation.

12.4 For Recommendation 3 (that there are 'robust systems in place to provide evidence that actions have been implemented in a timely manner and in line with the requirements of each action plan) the Trust has achieved Level 3. We have seen evidence that the Trust has established a series of committees and groups which provide oversight of the serious incident process. The grading of incidents is reviewed and can be challenged and all those involved in grading decisions meet regularly to review how the process works. The investigations themselves are kept under a rigorous control process to ensure that reports are produced on time and the action plans are implemented as planned.

12.5 We would suggest that more work is done to support the Quality Committee which is central to the whole process of overseeing the implementing serious incident recommendations.

12.6 The Trust Board has been successful in implementing some aspects of Recommendation 4 (at Level 2) that clinical staff have dedicated time for recording notes and record-keeping and that staff record the rationale for the clinical decisions they make and use risk assessment and formulation to inform relapse planning. It has improved training for staff on the quality of risk assessment and recording through the employment of a clinical lead for risk. Minimum standards for recording risk screenings, risk assessment and risk management plans have been adopted across the Trust for all professional groups. The Trust has proforma letters for psychiatrists to communicate their assessments in a standard form to GPs.

12.7 Some work has been done on protecting staff time for record-keeping and other administrative tasks through job planning but it isn't clear what proportion of the clinical workforce this covers. The amount of recording required has been reduced somewhat through changes in the risk assessment forms themselves. Many teams suffer from high caseloads and the situation is made worse by high levels of staff turnover and sickness absence. Some teams now have the responsibility of finding their own local solutions to protecting administration time.

12.8 A clinical audit was carried out in 2017/18 which found that there was considerable variation between the CDSs in terms of recording important aspects of care and treatment. Our own five per cent sample of adult-age service users in the community showed that recording information on 'high-risk or complex' cases was very nearly complete, though there were some variations around involving carers. When we looked at the whole sample by CDS there were also variations between the CDSs which echo those of the Trust's own clinical audits. The situation has improved since the Trust's own data collection in 2016. The Trust has changed the way information on risk assessment and management, crisis and contingency planning and care planning is recorded on Carenotes to encourage staff to explain the rationales for their judgements.

12.9 We conclude that the Trust Board has met all the requirements of Recommendation 5 at Level 3 as it has not only introduced a voice to text dictation system (Dragon Dictate), it has evaluated its use across the Trust and has learnt a number of valuable organisational lessons on how to introduce a major, sustainable, technological change. This is important as the Trust moves forward in its use of technology to improve service provision. The Trust has paired up with another Trust as part of the Global Digital Exemplars Project which is an important indicator of both its willingness to innovate and to learn from other's experiences. Clinical staffs' performance in completing records and improving productivity have both improved in ways the Trust can measure. The Trust has gone beyond the demands of our recommendation and we commend the Trust in their efforts to roll out the voice to text system more comprehensively.

12.10 The Trust Board went some way towards meeting the requirements of Recommendation 6 at Level 3 as it considered using a CPA review checklist but then decided that this was not the most appropriate way forward. The Trust has produced a checklist for service users and carers which they can use to

contribute to CPA reviews. This is not the local tool we recommended staff could use to prepare for each CPA review which management could then use locally to audit the CPA process.

12.11 However, the Trust has accepted the requests of service users and carers and has accepted the need for Personal Support Plans to be co-produced with service users and carers. The Trust has worked on developing a person-centred, recovery focussed approach to care planning.

12.12 The Trust had done some excellent work in relation to evaluating the training and development they provide (Recommendation 7, requirements met at Level 3). The pilot evaluation of the clinical risk e-learning package, to Kirkpatrick levels 1 and 2 was thorough and detailed, although with a small sample of respondents.

12.13 We commend the Trust for carrying out this pilot study and would encourage the Trust to follow through on the recommendations to continue to develop ways of evaluating the impact of training and other learning and development activities.

12.14 We appreciate that more extensive and formal evaluations will have resource implications which present challenges for the Trust. The Trust Board has already identified one route for extending evaluation in the pilot evaluation of clinical risk e-learning. The recommendation has been made that the Trust Board and academic partners should encourage staff who are undertaking Master's level education to lead on evaluations of the impact of training (as in the Kirkpatrick model). This approach has been used elsewhere to evaluate training using the Kirkpatrick model in full.

12.15 However, we also recognise that the Trust is putting significant resources into alternative learning and development opportunities such as the OD programme, the QI programme, the Safety Collaboratives, the RRI Action Plan and the TDDs.

12.16 The Trust has provided evidence of evaluating training as part of wider initiatives which have led to changes in practice. There are examples which represent a Trust-wide approach to evaluating the experience and learning from training and education activities. The evaluations clearly demonstrate that staff value these events positively, and the Trust has provided extensive evidence that they are creating the conditions for training and education to have a positive impact on practice and on the organisation's goals.

12.17 The Trust Board has met the requirements of Recommendation 8 that the Trust 'aim to achieve membership of the national Triangle of Care programme within 12 months' at Level 3 as it has demonstrated its commitment to ToC at the highest level of the organisation. It has made significant strides in the support provided to and involvement offered to carers since 2016. We welcome the CEO's commitment that ToC will remain a key component of the Trust's strategy. The Trust-wide Carer Leader has made a critical contribution to the progress the Trust has made.

12.18The Trust is clearly continuing to act on its commitment to implementing the Triangle of Care approach to involving carers in the care and treatment of service users. We fully commend the Trust's impressive work towards achieving full ToC accreditation, which is also acknowledged by external bodies.

12.19The current level and grade of support, and resources for this work need to remain solely focussed on ToC implementation.

12.20We were impressed by the Trust's commitment to using QI as a tool for organisational and cultural change, and by the enthusiasm and knowledge shown by the two members of the QI team whom we spoke to. We note that this model is aligned to the Triangle of Care, to their focus on person-centred care and to their OD programme. We again commend the Trust for their commitment to and investment to these developments.

12.21Overall, we felt that the tone of the SPFT CQPG meetings demonstrated a culture where commissioners and the Trust were working collaboratively to improve quality and safety – both in response to serious incidents and more generally. The CCG has provided clear evidence of effective monitoring of serious incident investigations and action plans. The CCG's approach is consistent with NHS England (2015).

Next steps

12.22We believe that while the Trust Board continue to develop the activities and initiatives prompted by the Thematic Homicide Review generally (as noted above) there are some specific Next Steps the Trust Board might wish to consider.

1. Continuing the work being done on co-producing activities such as training, recording, QI and widening the use of co-production wherever possible as this work seems to be improving the standards of training and record-keeping, as well as the experience of service users and carers.
2. Carrying out a clinical risk assessment and care planning re-audit as soon as conditions permit.
3. Assuring itself that clinical supervision is used to help staff integrate their learning into their daily practice and that improvements in performance follow.
4. Monitoring and reducing unwanted differences in the experiences of service users and carers in receipt of the Trust's services which the Trust's own data collection, the People Participation Group and our own five per cent sample of service users have identified.
5. Employing more systematic methods so the Trust can understand the 'added value' the resources put into education and training bring to its activities.

12.24We also regard the support being given to the QI programme and the culture change it promotes as a critical method for improving the Trust's performance

in areas that have so far proved less tractable to previous methods of organisational change.