Mental Health Homicides Thematic Review:

Quality Assurance Review

Volume II Appendices

September 2019

Mental Health Homicides Thematic Review: Quality Assurance Review. Volume II Appendices

Version number: Draft final report

First published: TBA

Updated: 2 September 2019

Prepared by: Ms Maggie Clifton (Review Manager, Caring Solutions (UK) Ltd)

Dr Tony Fowles (Senior Associate, Caring Solutions (UK) Ltd)

Dr Colin Dale, (Chief Executive, Caring Solutions (UK) Ltd) provided quality assurance for this review and report.

Mr Alan Worthington (Lay member) provided expert advice regarding the Triangle of Care and carer involvement.

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

Web: Caring Solutions UK Ltd

Contents

Appendix A Members of the review team

The team for this Quality Assurance Review consists of two senior associates with expertise in thematic analysis, benchmarking and quality assurance, and a lay carer to provide a further independent perspective on the work, supported by the Chief Executive of Caring Solutions (UK) Ltd. All members of the team have extensive experience in independent investigations.

Dr Colin Dale: Dr Dale has been an Executive Nurse in three NHS Trusts; has worked as a professional adviser to the RCN, NIMHE, NPSA and the Department of Health and has a track record of research publications and international conference presentations. He has successfully worked on many projects in recent years including: national projects with the Royal College of Nursing, the Offender Health Services, the Youth Justice Board together with a number of local and regional projects for individual Trusts and organisations. Colin has led: the review of 38 Homicides by Mental Health Service Users in the North West of England; the thematic review of 40 Homicides by Mental Health Service Users in London; the review of 81 unexpected deaths in the North East of England; and works as an independent investigator in SUIs in the health and prison services. He is a member of the Mental Health Review Tribunal and was the mental health adviser with the National Patient Safety Agency.

Ms Maggie Clifton, MA, MCMI: (Review Manager and Senior Associate). Maggie has managed and contributed to several Independent Investigation Panels, for former SHAs and for NHS England, and to the review and audit of internal and independent SUI investigation reports. She trained and worked as a social scientist, specialising in qualitative research including interviewing, documentary and transcript analysis and report-writing, in health and social policy related areas. She is also a qualified general manager with extensive experience in the voluntary sector of managing services for homeless people and for people with long-term mental health problems. She is currently an independent research and management consultant, specialising in quality assurance, mental health service development, and training and development for managers. As an independent management consultant she has worked on projects for the Department of Health, Royal College of Nursing, Primary Care Trusts, Universities of Liverpool and Lancaster. She is currently a Senior Associate and Investigations Manager for Caring Solutions (UK) Ltd and consultant to The Development Partnership and British School of Coaching. She is trained in advanced investigation skills and in the use of the European Foundation for Quality Management Excellence Model.

Dr Tony Fowles — Tony is a Senior Associate at Caring Solutions (UK) Ltd and is a specialist in criminal justice with a background in research and university teaching; including being Dean of the Law School at Thames Valley University. He was the lead reviewer for the NHS London project, 'Learning from Experience – report of consultancy to support the compilation and analysis of learning from the 2002-2006 London mental health homicide reviews and analyses'. He was chair/lead investigator of two independent inquiries into the care and treatment of mental health service users. The inquiries were commissioned by NHS London SHA and NHS Yorkshire and the Humber SHA. He has also provided specialist criminal justice input into other independent inquiries carried out by Caring Solutions (UK) Ltd. In

2013 he produced 'Lessons Learnt from Independent Inquiries, a report prepared for Mersey Care NHS Trust'. In 2015 he was the chief technical editor of the revised Reference Guide to the Mental Health Act 1983.

For eight years Tony was a criminologist member of the Parole Board of England and Wales which is responsible for the early release of prisoners. This work involved assessments of risk, for example, further violent offences as well as reputational risk. He was Chair of the Lancashire Probation Board between 2002 and 2007. Tony has published several books on criminal justice and was from 1997 to 2008 one of the Editors of the Howard Journal of Criminal Justice which is Britain's main criminal justice policy journal. He is currently a member of the editorial advisory board of the Journal of Intellectual Disabilities and Offending Behaviour.

Mr Alan Worthington – lay member, carer. Formerly in science education, he 'retired' early to become a carer of twin foster sons who developed psychosis in 1988. Soon afterwards he was appointed in Exeter to develop support and education services for mental health carers becoming one of the first Carers' Support Workers in the country. This work involved identifying Best Practice and finding ways for its introduction into carer involvement. For several years he worked for both MIND and the National Schizophrenia Fellowship and organised training days and conferences for staff and carers. He has contributed to the Care Quality Commission's inspection standards; participated in the Royal College of Psychiatrists' Accreditation – Peer Assessment Schemes; both in the Inpatient (AIMS) programme and the Crisis-Home Treatment (HTAS) Scheme. In the latter, he took part in the process of selecting Standards for Home Treatment and is currently involved in the HTAS Awarding process. He is a member of the Department of Health National Mental Health Safety Advisory Committee which is currently looking at ways of applying the Safety Thermometer concept to the reporting of mental health risk. His previous experience of investigations in care and treatment include a Review of 5 SUI Cases in Cornwall and an SUI Conference run by DH in Leeds in 2009. Mr Worthington brings an independent voice and challenge to the review process.

Appendix B References and source materials

Non-Trust documents

Arjmandi, R., Basirinezhad, M. H., Lahijanian, A. O., and Rahimizadeh, A. (2018) Effectiveness of Health, Safety, and Environment Training Courses Using the Kirkpatrick Model and Providing Managerial Solutions for the Staff of Sinadarou Company, Journal of Biomedicine and Health, 3, 1, 54-61 [Rec 7]

Brimstin, J. (2016) Maneuver Center of Excellence Program Evaluation, Career Programme 32, pp 6-7. Paper presented at the Association for Talent Development annual conference [Rec 7]

Care Coordination Association – Care Planning Workshop presentation [Rec 6]

Caring Solutions (2017) Review of evidence of actions taken by Sussex Partnership NHS Foundation Trust following an independent investigation into the care and treatment of Mr RS [Rec 3]

Clarke-Mapp, J. and Shepherd, J. (2018) 'Good practice in sharing mental health information' in Careline, Care for the carers, Winter/Spring [Rec 8]

Carter, G., Milner, A., McGill, K., Pirkis, J., Kapur, N. and Spittal, M. (2017) Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. The British Journal of Psychiatry, 210: 387-95 [Rec 4]

CQC (2016a) Learning, candour and accountability — a review of the way NHS trust review and investigate the death so patients in England [Recs 1 and 2]

CQC (2016b) Sussex Partnership NHS Foundation Trust report of inspection 6, 7, 12 – 16, 20, 22, 29 September 2016 and Focused follow up inspections: 1 – 4 November and 7 December 2016

CQC (2018a) Sexual Safety on Mental Health Wards [Rec 2]

CQC (2018b) Learning from Deaths – a review of the first year of NHS trusts implementing the national guidance

CQC (2016) Sussex Partnership NHS Foundation Trust report of inspection 6, 7, 12 – 16, 20, 22, 29 September 2016 and Focused follow up inspections: 1 – 4 November and 7 December 2016

CQC (2018a) Sussex Partnership NHS Foundation Trust report of inspection 2 October – 7 December 2017

CQC (2018b) Sussex Partnership NHS Foundation Trust report of inspection 2 October – 7 December 2017 Evidence appendix

CQC (2019a) Sussex Partnership NHS Foundation Trust report of inspection 20 January to 28 February 2019

CQC (2019b) Sussex Partnership NHS Foundation Trust report of inspection 20 January to 28 February 2019 Evidence appendix

eLogic Learning How to easily implement (and automate) the Kirkpatrick model using an LMS July 25, 2018 [Rec 7]

Five-year forward view for mental health (2016) A report from the independent Mental Health Taskforce to the NHS in England.

Improving Carers' Experience (2018) 'Information booklet for mental health carers in East Sussex, West Sussex and Brighton and Hove' Amended March 2018 iceproject (accessed March 2019) [Rec 8]

Kirkpatrick Partners (accessed April 2019) [Rec 7]

Mazars (2015) Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015, Mazars [Rec 2]

Mid Staffordshire Foundation Trust Public Inquiry chaired by Robert Francis QC. Report published in 2013 Francis Inquiry report (accessed 28 August 2019) [Rec 2]

National Quality Board (2017) National Guidance on Learning from Deaths – a framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care [Rec 1]

National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (2017) Annual Report 2017.University of Manchester [Rec 1]

NHS England (2105) Serious Incident Framework – supporting learning to prevent recurrence

Naylor, S., and Ross, C. (2017) Quality Improvement in Mental Health. The King's Fund [Recs 4 and 7]

Niche (2015) 'What Safety Lessons can we learn? Thematic Review of independent homicide investigations' [Rec 1]

Niche (2018) An independent investigation into the care and treatment of a mental health service user Mr W in Sussex Independent investigation report Mr W (accessed 28 August 2019) [Rec 1]

Stevens, J., Butterfield C., Whittington, A. and Holttum S. (2018) Evaluation of Arts based courses within a UK Recovery College for People with Mental Health Challenges, Int. J. Environ. Res. Public Health **2018**, *15*(6), 1170 [Rec 7]

SPFT Triangle of Care Update in Worthing Rethink Newsletter, 16 November 2018 [Rec 8]

Verita (2014) Independent investigation into the care and treatment of Mr M and Mr P – A report for NHS England Independent investigation report Mr M and Mr P (accessed 13 May 2016) [Rec 4]

Ya-Hui Elegance Chang (2010) An Empirical Study of Kirkpatrick's Evaluation Model in the Hospitality Industry Florida International University. University Graduate School FIU Electronic Theses and Dissertations [Rec 7]

Trust policies

Carers and Confidentiality Policy 7 July 2016 [Rec 8]

Clinical Risk Assessment and Safety Planning/Risk Management Policy and Procedure (policy number TP/CL/008) ratified 7 August 2017 [Rec 4]

Clinical Strategy – the next steps in our journey 2017-2020. November 2017 [Rec 1]

Complaints Policy (policy number TPCO/058) v.4 ratified 23 August 2017 [Rec 1]

Care Programme Approach Policy (Including Standard Care) (policy number clinical. 189) final version ratified January 2016 [Rec 6]

Care Programme Approach Policy (Including Standard Care) (policy number TPCL/006) v. 3 ratified 29 November 2017 [Rec 6]

CPA Policy (including standard care) Policy on a Page [Rec 6]

Duty of Candour (Being Open) Policy (policy number TP/CL/004) v.2 November 2017 [Rec 2]

Duty of Candour (Being Open) Policy August 2017 [Rec 8]

Duty of Candour Policy on Page 2017 [Recs 2 and 8]

Incidents and Serious Incidents – Policy on a Page [Rec 1]

Incidents, Serious Incidents and Learning from Deaths Policy and Procedure (policy number TP/RHS/158 v.6) ratified 22 June 2018 [Recs 1, 2 and 8]

Job Planning Policy – Medical Staff (non-training grades) (policy number TPWF/218) v 4 December 2015 (currently under review) [Rec 4]

Serious Incidents Policy: Guidance for working with families/carers following a serious incident [Rec 8]

Supervision Policy (policy number TPWF/236) v 2 ratified 24 February 2017 [Rec 4]

Trust documents

Acute Care Conference programme (June 2019) [Rec 7

Acute Care Conference (June 2019) Evaluations [Rec 7]

Annual Training Plan April 2019 – March 2020 [Rec 7]

Board of Directors minutes of meeting 28 March 2018: 'TBP10.4/18 Family Story' [Rec 8]

Board of Directors meeting 23 May 2018 – agenda and papers

Board of Directors meeting 25 July 2018 – agenda and papers

Board of Directors meeting 26 September 2018 – agenda and papers

Board of Directors meeting 28 November 2018 – agenda and papers

Board of Directors meeting 30 January 2019 – agenda and papers

Board of Directors meeting 27 March 2019 – agenda and papers

Board of Directors meeting 22 May 2019 – agenda and papers

Briefing for Staff – Niche investigation – an independent investigation into the care and treatment of a mental health services user – Mr W in Sussex [Rec 2]

Cardio Metabolic Assessment and Treatment Training – improving physical health care for people who use mental health services – "Closing the Gap" – PowerPoint presentation [Rec 2]

Care Home Plus – Quarterly Quality Assurance Meeting 1 April 2019 [Rec 1]

Carenotes Change Meeting 24 January 2019 – minutes

Care Notes and CPA Meeting – minutes of meeting held on 1 March 2017

Care Notes and CPA Meeting – minutes of meeting held on 26 July 2017

Care Notes Carers Tab [Rec 8]

Care Notes Carers Information Form [Rec 8]

Care Notes Carers Information Report [Rec 8]

Care Plan Task Group and Finish Group – Terms of Reference [Rec 6]

Care Planning – Mental Health [Rec 6]

Care Planning Quality Improvement Meeting minutes of meeting held on 25 January 2017 [Rec 6]

Care Planning Quality Improvement Meeting minutes of meeting held on 18 October 2017 [Rec 6]

Care Planning Quality Improvement Meeting minutes of meeting held on 17 January 2018 [Rec 6]

Carer Friendly Communities Award to SFPT, October 2017 [Rec 8]

Carers Rights Day November 2017 – promotion and request for information [Rec 8]

Carers Rights Day celebrations November 2016 [Rec 8]

Carers Rights Day November 2018 [Rec 8]

Carers Rights Day Poster November 2018 [Rec 8]

Carers support and confidentiality: Brief guidance for staff (undated) [Rec 8]

Celebrating Carers Week – 11-17 June 2017 [Rec 8]

Celebrating Carers Week in style, June 2017 [Rec 8]

CEO Briefing: Launch of Triangle of Care – October 2017 [Rec 8]

ChYPS and EI CDS – Quarterly Quality Assurance Meeting – 11 April 2019 [Rec 1]

Clinical Academic Groups – Experts by Experience spreadsheet – 7 December 2018 [Rec 7]

Clinical Message of the Month – learning from mortality reviews – Diabetes – November 2018 [Rec 2]

Clinical Message of the Month – learning from mortality reviews – Clozapine – December 2018 [Rec 2]

Clinical Message of the Month – learning from mortality reviews – Sepsis – January 2019 [Rec 2]

Clinical Risk Assessment meeting held on 25 September 2018 – minutes [Rec 4]

Clinical Risk Assessment Training – attendance register – November 2018 [Rec 4]

Clinical Risk Assessment Training – evaluation charts – January to June 2019 [Recs 2, 4 and 7]

Clinical Risk Assessment Training – project progress report for Health Education England 12 July 2019 [Recs 2 and 7]

Clinical Risk Training for Nursing Assistants and Support Workers October/November 2018 – PowerPoint presentation [Rec 4]

Clinical Risk Training for Qualified Staff October/November 2019 – PowerPoint presentation [Rec 4]

Clinical Strategy – the next steps in our journey 2017-2020. November 2017 – version 2 – final [Rec 1]

Clinical Strategy service user feedback [Rec 1]

Collaborative Care Planning – Making personal support plans more meaningful – training flyer [Rec 6]

Collaborative Review of Unexpected Inpatient Deaths – confidential serious incident briefing for staff [Rec 1]

Complex Complaints – minutes of meeting held 19 December 2018 [Rec 1]

Confidential briefing for community staff – homicide and attempted homicide – January 2019 [Rec 2]

CPA – My Personal Support Plan [Rec 6]

CPA Review Checklist Implementation plan May 2017 [Rec 5 and 6]

Don't Miss Your Opportunity to Discuss the Clinical Strategy – invitation to attend Clinical Strategy Engagement Event [Rec 1]

Dragon User Survey – September 2018 [Ref 7]

Education Quality Performance Report Effective Care and Treatment Half-year Report, August 2018 [Rec 7]

Effective Care and Treatment Committee – Terms of Reference [Rec 7]

Effective Care and Treatment Committee – Role description: service user consultant /carer consultant [Rec 7]

Effective Care and Treatment Committee – attendees and minutes, 30 August 2017 [Rec 7]

Effective Care and Treatment Committee – attendees and minutes, 2 August 2018 [Rec 7]

Evaluation of Nursing Assistant Risk Assessment Training session – spreadsheet and histograms [Rec 4]

Family and Friend Carers: A guide to support and confidentiality (undated) [Rec 8]

Family Liaison Training – draft running order [Rec 2]

Family Liaison Lead leaflet [Rec 8]

Family Liaison Leads (FLL) Training 2019 – dates, overview and learning outcomes [Rec 2]

Family Liaison Lead Training 2019 [Rec 8]

Family Liaison Leads – working with families during an SI Investigation, February 2019 [Rec 2]

GDE (Global Digital Exemplar) Digital Programme Board minutes of the meeting held on 13 November 2018 [Rec 5]

GDE Digital Programme Board meeting held on 31 January 2019 – agenda and papers [Rec 5]

Global Digital Exemplar Community – Implementing Voice to Text Solution into an Electronic Health Record dated 8 February 2019 [Rec 5]

GDE – Digital Highlights paper for Operational Management Board meeting 7 February 2019 [Rec 5]

Guidance and feedback booklet for Safety and Quality Reviews [Rec 3]

Guidance for staff – Recording Main Presenting Mental Health Problems Improving Recording of Main Presenting Mental Health Problems [Rec 5]

Guidance for staff – Improving Recording of Main Presenting Mental Health Problems [Rec 5]

Homicide Thematic Review action plan update – July 2018 [Rec 8]

Improving Recording of Main Presenting Mental Health Problems [Rec 5]

Incident and SI Governance Process [Rec 1]

Integrated clinical risk and care plan clinical audit March 2018 (Clinical Audit Team) [Recs 4, 6 and 7]

Integrated Performance February – PowerPoint presentation [Rec 1]

Integrated Performance Report paper for Board of Directors meeting held on 27 March 2019 [Recs 1, 4 and 6]

Job Plan for A&T OT, Band 6: 30 hours [Rec 4]

Job Plan for A&T Peer: 22.5 hours [Rec 4]

Job Plan for A&T STR: based on 1.0 whole-time equivalent = 37.5 hours [Rec 4]

Learning from Medication Incidents – PowerPoint presentation [Rec 2]

Learning from Serious Incidents – PowerPoint presentation June 2018 [Rec 2]

Learning from Serious Incidents Conference September 2018 – Agenda, Attendees and Evaluation [Recs 2, 7 and 8]

'Learning from when things go wrong' – evaluation and feedback – Q1 'Was event useful to me?'; 'Three words that best sum up the day'; 'Which sessions was least relevant to you?'; 'Which session was most relevant to you?'; 'Is there anything else you'd like to share about the event?'; list of attendees [Rec 2]

"Making Families Count" – conference 13 June 2017 – flyer on conference purpose and outcomes for individuals and organisation [Rec 2]

"Making Families Count – family experiences of NHS investigations" – workshop 13 June 2017 – an evaluation [Rec 2]

Mandatory and Statutory training – compliance trajectory: Executive Management Committee paper (January 2019) [Rec 7]

Mandatory and Statutory training – compliance trajectory: Effective Care and Treatment Committee paper (May 2019) [Rec 7]

Mandatory and Statutory training – compliance trajectory; Supervision and Appraisal: Effective Care and Treatment Committee paper (July 2019) [Rec 7]

Matching "Main Presenting Mental Health Problems" with ICD10 codes [Rec 5]

Mental Health Awareness Training for SPFT Non-Clinical Staff – flyer for courses [Rec 7]

Minimum Standards for the Recording of Risk Screening, Assessment and Management Plans in Adult, Learning Disability, and Forensic Healthcare (February 2017) [Rec 4]

Minutes of Complex Complains meeting held on 19 December 2018 [Rec 1]

Minutes of Serious Incident Grading Workshop held on 27 September 2018 [Rec 1]

Monitoring SI Action Plan Review and Closure [Rec 1]

National CQUIN 3b – collaboration with primary care clinicians audit report – Sussex Partnership NHS Foundation Trust – January 2019 (Clinical Audit Team) [Rec 5]

New Carenotes Change Structure – organisation chart

New Governance Structure Meetings – committees and meeting chairs including carers or patient chairs [Rec 1]

Not, 'Just an Admin' – Celebrating the Administrative Profession – day conference to be held on 22 November 2018 [Rec 7]

Notes from clinical strategy/Hackathon meeting with service users [Rec 1]

Open SI Actions Plans – report produced 04/02/2019 [Rec 1]

Operations Management Board – agenda and papers for meeting 7 February 2019 [Recs 1 and 3]

Organisational Development Update – 6 December 2018 [Rec 7]

Organisational Development Days – list of attendees, events, summary of contents and training facilitator at 8 March 2019 [Rec 7]

Organisational Development Practitioners' Service – Interventions offered as part of this service [Rec 7]

Organisational Development Programme Update – report for Well-led and Workforce Committee – 7 June 2018 [Rec 7]

Our 2020 Vision – feedback from our strategy refresh events [Rec 1]

Our Approach to Quality Improvement – 26 April 2017 [Rec 4]

Overall evaluation of North West Sussex Risk Assessment Training – spreadsheet and histograms [Rec 4]

Overall evaluation of Qualified Risk Assessment Training to date January – March 2019 – spreadsheet and histograms [Rec 4]

Partnership Matters (SFPT Magazine) January 2017: 'What am I doing here? – role of Carer Leader' [Rec 8]

Patient Safety Learning Event – evaluation template [Recs 2 and 7]

Patient Safety Learning Event – Learning and Improving – 'Clinical Risk' – 18 April 2018 agenda, speakers and sessions [Rec 2]

Patient Safety Learning Event – Learning and Improving – 'Risk Assessment and Involving Carers' – June, July and September 2018 – evaluation data [Recs 2 and 7]

Patient Safety Learning Event – Learning and Improving – 'Safeguarding Adults and Children' – September, October and November 2018 – evaluation data [Recs 2 and 7]

Patient Safety Learning Event – 'Learning from Serious Incidents and Mortality Reviews – Physical Health and Medications' – flyer with dates and locations, agenda, who should attend and expected outcomes, conference programme, list of attendees – April 2019 [Rec 2]

Patient Safety Learning Event – Learning and Improving – 'Learning form Serious Incidents and Mortality Reviews – Physical Health and Medications' – evaluation data [Rec 2]

Patient Safety Learning Event – Learning and Improving – a specialised event for Chapel Street on Local Serious Incidents – September 2019 – evaluation data [Recs 2 and 7]

Patient Safety Matters – January 2018 – Involving families in care [Rec 2]

Patient Safety Matters – March 2018 – Working with people with a diagnosis of personality disorder [Rec 2]

Patient Safety Matters – May 2018 – Driving Licensing Agency (DVLA) and Clinical Care [Rec 2]

Patient Safety Matters – August 2018 – Safeguarding Children [Rec 2]

Patient Safety Matters – October 2018 – Falls [Rec 2]

Personal Recovery Plan [Rec 6]

Personal Support Planning – working together to agree your care [Rec 6]

Preceptorship Programme Study Days – list of sessions, learning outcomes and reading materials [Rec 2]

Preceptorship Programme – flyer 1 draft [Rec 2]

Preceptorship Programme – cohort 2 flyer [Rec 2]

Preceptorship Programme – cohort 3 flyer [Rec 2]

Preparing to Discuss My Personal Support Plan [Rec 6]

Preventing and Managing Violence and Aggression 5-day Theory Session – Aims [Rec 7]

Providing Clinical Risk Training to Clinicians – (Face to Face) Project Progress Reporting to Health Education England [Rec]

Psychiatrist's proforma letter to GP following clinic [Rec 4]

Quality Committee – Agenda for meeting to be held on 18 December 2018 [Rec 1]

Quality Committee – Agenda and papers for meeting 19 June 2019 [Rec 1]

Quality Committee restructure – paper for Board of Directors meeting 13 September 2017 [Rec 1]

Quality Committee Terms of Reference approved by the Trust Board at meeting May 2019 operative from that date [Rec 3]

Quality Committee Summary Report paper for Board of Directors meeting held on 27 March 2019

Quality Improvement Programme Update – report for Quality Committee meeting 22 August 2018 [Rec 4]

Quality Improvement Programme Update – report for Quality Committee 31 October 2018 [Rec 4]

Quality Improvement Programme Update – report for Quality Committee 18 December 2018 [Rec 4]

Quality Improvement Programme Update – report for Quality Committee 12 February 2019 [Rec 4]

Quality Improvement Strategy – What is QI? [Rec 4]

Quality Improvement Strategy Delivery Plan – paper for Trust Board meeting 23 May 2018 [Rec 4]

Quality and Patient Safety Report Quarter 2, 2018/19 1st July – 30th September 2018 by Deputy Chief Nurse, Clinical Governance Team [Rec 1]

Quality and Safety Review Timetable – April 2018 – Rehabilitation Services and Learning Disabilities – dates, venues and personnel [Rec 3]

Quality and Safety Review Timetable – May 2018 – Adult Wards – dates, venues and personnel [Rec 3]

Quality and Safety Review Timetable – June – CAMHS Inpatient and Community – dates, venues and personnel [Rec 3]

Quality and Safety Review Timetable – September 2018 – Linbridge and Older People's Wards – dates, venues and personnel [Rec 3]

Reducing Restrictive Interventions 5-day timetable (October 2018) [Rec 7]

Reducing Restrictive Interventions Plan (June 2019) [Rec 7]

Reducing Restrictive Interventions – progress report – report to the Safety Committee – 7 January 2019 [Recs 1 and 7]

Reducing Restrictive Practice – presentation by ward managers for the PICU wards [Rec 7]

Report to Board of Directors meeting 'Our Ten Commitments to Carers and the Triangle of Care', 24 May 2017 [Rec 8]

Report to Operational Management Board – 'GDE – Digital Highlights' for meeting to be held on 7 February 2019 [Rec 5]

Report to Quality Committee meeting 'Exceptions Report Safety Committee', 22 August 2018 [Rec 8]

Report to Trust Executive Committee 'Serious Incident Assurance Report' 22 January 2019 [Rec 8]

Risk Assessment Guidance for completing new version of risk assessment Carenotes from December 2018 [Rec 4]

Risk assessment meeting held on 29 November 2018 – minutes [Rec 4]

Root Cause Analysis (RCA) training – Day 1 [Rec 2]

Root Cause Analysis (RCA) training – Day 2 [Rec 8]

RSM Risk Assurance Services LLP – Sussex Partnership NHS Foundation trust Implementation of Serious Incident Action Plans – Final – Internal audit report 14.17/18 – 16 April 2018 [Rec 1]

Safety Committee – agenda and minutes for meeting on 5 November 2018 [Rec 8]

Safety Committee – agenda and papers for meeting on 7 January 2019 [Rec 1]

Safety Committee – agenda and papers for meeting on 11 March 2019 [Rec 1]

Safewards – event poster [Rec 2]

Safewards and Restrictive Interventions – note on progress after launch event in March 2019 [Rec 2]

Serious Incident Annual Report – report for Board of Directors for meeting 27 June 2018 [Rec 1]

Serious Incident Assurance Report – report for Trust Executive Management Committee 22 January 2019 [Rec 2]

Serious Incident Grading Workshop – minutes of meeting held 27 September 2018 [Rec 2]

Serious Incident Assurance Report for Trust Executive Committee held on 22 January 2019 [Rec 2]

Service Delivery Board: constitution, duties, authority, members, quorum, frequency, calling meetings, reporting, and communication [Rec 1]

Service User feedback (Hackathon) [Rec 1]

Service User and Carer Quality and Safety Review feedback for Crawley CRHT on 25 September 2017 [Rec 3]

Service User and Carer Quality and Safety Review feedback for Linwood CMHC on 8 February 2018 [Rec 3]

Service Users and Carers Quality visits – programme for February – April 2018 [Rec 3]

Supporting Safer Inpatient Services – workshop programme of topics and speakers [Rec 2]

Supporting Safer Inpatient Services – summary of feedback [Rec 2]

Sussex Partnership Quality and Patient Safety Report, Q2 2018/19, 1 July 2018 – 30 September 2018 [Rec 1]

Sussex Partnership Quality and Patient Safety Report, Q4 2018/19 1 January to 31 March 2019 [Rec 7]

Sussex Recovery College – Prospectus West Sussex 2018-2019 [Rec 7]

SPFT website – Triangle of Care pages: The Trust, Triangle of Care (accessed March 2019) [Rec 8]

SPFT Welcome Conference (Induction) Day 1 2019 [Rec 8]

SPFT Education and Training Department, Clinical Risk Assessment and Safety Planning/Risk Management Training: a pilot study of evaluation of impact on practice [Rec 7]

Table on Carers' '10 must dos' from Hackathon: Identifying how they are being taken forward, July 2018 [Rec 8]

Together for Carers: Stakeholder workshop for Sussex and East Surrey STP October 2018 Flyer [Rec 8]

Tools for Safety and Quality Reviews [Recs 1 and 3]

Triangle of Care Advisory Group: Terms of Reference February 2017 [Rec 8]

Triangle of Care Advisory Group minutes of meeting November 2017 [Rec 8]

Triangle of Care Advisory Group minutes of meeting March 2018 [Rec 8]

Triangle of Care Advisory Group minutes of meeting June 2018 [Rec 8]

Triangle of Care Advisory Group minutes of meeting September 2018 [Rec 8]

Triangle of Care Advisory Group minutes of meeting December 2018 [Rec 8]

Triangle of Care Carers Pack cover, September 2018 [Rec 8]

Triangle of Care – one year on. October 2018 [Rec 8]

Triangle of Care self-assessment tool (Appendix 1) undated [Rec 8]

Triangle of Care tweets SFPT twitter account, November 2018 [Rec 8]

Trust Governance and Committee Structure (PowerPoint presentation [Rec 1]

Trust-wide Complaints Report as at 29 January 2019 [Rec 1]

Update to Inpatient Review Action Plan – Collaborative Review of Unexpected Inpatient Deaths – report to Quality Committee 12 February 2019 [Rec 1]

'What happens when things go wrong' (August 2017) produced by the Governance Support Team [Rec 2]

What happens when things go wrong? (Duty of Candour leaflet for patients and families) undated [Rec 8]

"What is a good care plan?" Three engagement events – August 2018 – Summary to date of Real Insight's findings, from the voices and views of the participants' themselves [Recs 5 and 6]

"What matters to you" Hackathon evaluation [Rec 1]

"What matters to you?" Hackathon Report – the Trust's patient and carer experience improvement journey 2016/17 [Rec 1]

Where can we place actions for each of the Hackathon tables and how will they be monitored? [Rec 1]

Young Carers Awareness Day – 25 January 2018 promotion [Rec 8]

Young Carers Awareness Day – 31 January 2019 and tweet promotion [Rec 8]

Clinical commissioning groups

Clinical Quality and Performance Group – Terms of Reference – Draft v5 Sussex Partnership NHS FT – 31 December 2018

SPFT Clinical Quality and Performance Group M07 Agenda for 19 December 2018

SPFT Clinical Quality and Performance Group M08 Notes for 19 December 2018

SPFT Clinical Quality and Performance Group M08 Agenda for 16 January 2019

SPFT Clinical Quality and Performance Group M08 Notes for 16 January 2019

SPFT Clinical Quality and Performance Group M09 Agenda for 20 February 2019

SPFT Clinical Quality and Performance Group M09 Notes for 20 February 2019

SPFT Clinical Quality and Performance Group M10 Agenda for 20 March 2019

SPFT Clinical Quality and Performance Group M10 Notes for 20 March 2019

SPFT Clinical Quality and Performance Group M11 Agenda for 17 April 2019

SPFT Clinical Quality and Performance Group M11 Notes for 17 April 2019

Monthly Serious Incident Report – December 2018 and January 2019 for Quality and Safety Committee meeting 13 March 2019

Serious Incident Report – February and March 2019 Report for Quality and Safety Committee

STP CCGs Policy and Procedures for Reporting and Managing Incidents and Serious Incidents – March 2019

Policy and Procedures for Reporting and Managing Incidents and Serious Incidents v9 October 2018

STP CCGs Policy and Procedures for Reporting and Managing Incidents and Serious Incidents for Quality and Safety Committee on 13 March 2019

Appendix C Abbreviations used in the report

ADHD	Attention deficit hyperactivity disorder
AHSN	Academic Health Sciences Network
AOT	Assertive Outreach Team
ATS	Assessment and Treatment Service
CAGs	Clinical Academic Groups
CCG	Clinical Commissioning Group
CDS	Care Delivery Service
CEO	Chief Executive
CMB	Contract Management Board
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuous Professional Development
CQC	Care Quality Commission
CQPG	Clinical Quality and Performance Group
CRHTT	Crisis Resolution and Home Treatment Team
DNA	'Active Engagement or Did Not Attend' policy
ECAT	Effective Care and Treatment Committee
EIP	Early Intervention Programme
EMC	Executive Management Committee
EPR	Electronic Patient Record (Carenotes)
ESBT	East Sussex Better Together
GP	General Practitioner
HCA	Health Care Assistant
HEE	Health Education England
HMP	HM Prison
HR	Human Resources
IHI	Institute for Healthcare Improvement
KPIs	Key Performance Indicators
KSS	Kent, Surrey and Sussex (region of HEE)
NHS E	NHS England
NHSI	NHS Improvement (now merged with NHS England)
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
OD	Organisational Development
ODP	Organisational Development Practitioner
OMB	Operational Management Board
OT	Occupational Therapist
PICU	Psychiatric Intensive Care Unit
PSP	Personal Support Plan
QAR	Quality Assessment Review
QI	Quality Improvement
RAG	Red, Amber, Green
RCA	Root Cause Analysis
RI	Restrictive Interventions
RRI	Reducing Restrictive Interventions
SES	Sussex and East Surrey

SI	Serious Incident
SMART	Specific, Measurable, Attainable, Relevant and Time-based
STEIS	Strategic Executive Information System
STP	Sustainability and Transformation Partnership
STR	Support Time and Recovery Worker
SUI	Serious Untoward Incident
TDD	Team Development Day
ToC	Triangle of Care

Appendix D Analysis of a sample of working-age service users in the community

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 the Fundamental Standards of Care which they provided to us in an anonymised format. Although the numbers are relatively small, it has been possible to analyse the sample by the level of risk or complexity posed by the service users and by CDS.

Tables 1 to 15 show how these service users were dealt with by the Trust in terms of five major aspects of treatment and care when the sample is analysed by the level of risk or complexity. These are referred to hereafter as 'high' or 'low' risk to avoid repetition. We might expect that high-risk or more complex cases should have more attention devoted to them by staff and that risk assessments were more likely to be complete or that contingency planning would be more detailed. There is always the caveat that high risk is not necessarily a good predictor of outcomes such as suicide[1].

The tables are shown using actual numbers as the use of percentages based on small numbers of cases may be misleading. The data presented below should be regarded as indicative rather than definitive. It is not clear how representative of the population of working-age service users in the community this sample is.

Table 1 The distribution of 'high' and 'low-risk' cases by Care Delivery Service

CDS	High risk or complex[2]	Low risk or not complex[3]	Total
Brighton and Hove	2	24	26
CHYPs EIP	1	5	6
Coastal West Sussex	9	29	38
East Sussex	5	18	23
North West Sussex CDS	5	22	27
TOTAL	**22**	**93**	**120**

[1] 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

[2] 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'.

[3] 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'

This table should not be used to draw the conclusion that Coastal West Sussex CDS works with over a third of all the 'high-risk or complex' cases who are Trust service users. This sample is random rather than stratified by risk or by CDS.

The safest conclusion to draw from the table is 22 of the sample of 120 were 'high-risk' cases in terms of their presentation and that these cases are spread across the larger CDSs.

As the number of cases in the sample is relatively small, the numbers decrease very rapidly if the sample is analysed by Team so this variable has not been used in this analysis. The CHYPs EIP CDS cases have been excluded from the analysis presented in Tables 2 to 20 because there were no cases under the care of the Children and Young Persons CDS in the original Thematic Homicide Review as a result all the tables which follow in this Appendix total 114.

Comprehensive risk assessment

Table 2 If the person presents with significant high and/or complex risk, is there evidence of MDT and/or multi-agency input?

Evidence of MDT and/or multi-agency input	**High risk or complex**	**Low risk or not complex**	**Total**
Yes	21	-	21
Not applicable	-	93	93
TOTAL	**21**	**93**	**114**

This table shows that the cases in the sample have been subject to a Multi-Disciplinary Team meeting and/or to multi-agency input in accordance with Trust policy. All of the 'high-risk' cases had evidence of multi-disciplinary team or multi-agency input as would be expected from their level of risk.

Table 3 The risk formulation contains a narrative of how identified risk and protective factors combine to increase and decrease risk.

Narrative of risk and/or protective factors present	**High risk or complex**	**Low risk or not complex**	**Total**
Yes	20	89	109
No	1	4	5
TOTAL	**21**	**93**	**114**

The results in this table show that in almost all cases the risk formulation contains a narrative of how identified risk and protective factors combine to increase or decrease risk regardless of the level of risk the service user presents (109 out of 114). A narrative risk formulation was absent in only one of the 'high-risk' cases compared with four of the 'low-risk' cases. The inclusion of a narrative account is important as it should provide the rationale for the risk formulation. The narrative account approach also makes clear the reasoning process applied to the weighting of different pieces of information and is seen as representing progress beyond a

'tick-box exercise'. The absence of such rationales for conclusions and decisions was one of the emerging themes in the Thematic Homicide Review.

Table 4 Is the nature of the risk(s) recorded (e.g. violence to self or others, exploitation).

Nature of risk(s) recorded	High risk or complex	Low risk or not complex	Total
Yes	21	92	113
No	-	1	1
TOTAL	**21**	**93**	**114**

The nature of the risk posed was recorded in all the 'high-risk' cases and was absent in only one of the 'low-risk' cases and the risk assessments included vulnerabilities as well as the types of risk the service users might pose.

Risk Management

Table 5 Does the plan demonstrate an understanding of what factors/events increase risk and how likely they are to occur?

Plan demonstrates understanding of risk factors	High risk or complex	Low risk or not complex	Total
Yes	20	92	112
No	1	1	2
TOTAL	**21**	**93**	**114**

Again, nearly all the cases, regardless of risk level, had a risk management plan which demonstrated an understanding of the factors or events which were likely to increase risk and included an estimate of how likely these factors or events were to occur (112 out of 114 cases).

Table 6 Does the risk management plan demonstrate an understanding of what to do following increases/decreases in risk?

Plan demonstrates understanding of causes of relapse	High risk or complex	Low risk or not complex	Total
Yes	18	86	104
No	3	7	10
TOTAL	**21**	**93**	**114**

While an understanding of the factors which increase or decrease risk level is an important element in the preparation of a risk management plan, it is equally important to be able to specify what should be done following changes in risk levels. There was a risk management plan in 104 out of the 114 cases. This information was not present in three of the 'high-risk' cases and in seven of the 'low-risk' cases.

Table 7 The risk management plan targets identified risk factors and documents strategies/interventions aimed at preventing identified potential adverse events from

occurring and/or minimising the harm caused i.e. mediators – what are the protective factors, who can support the safety plan, what factors will impact on the safety plan e.g. withdrawal or increased self-harm.

Risk management plan covers interventions and mediating factors	High risk or complex	Low risk or not complex	Total
Yes	20	88	108
No	1	5	6
TOTAL	**21**	**93**	**114**

The completion rate for 'safety plans' was very high for the 'high-risk' cases – 20 out of 21 of cases and was only very slightly worse for the 'low-risk' cases – 88 out of 93 cases. These results mean that staff are thinking through the implications of what they have observed about the service users and have gone on to the next step of documenting strategies to reduce potential adverse outcomes from occurring. This may be through harm reduction if events do happen or through building up mediating factors which reduce the likelihood of the event occurring.

Crisis/Contingency Planning

The following three tables deal with how crisis or relapse contingency planning has been carried out.

Table 8 Does the crisis/contingency plan include personalised signs and symptoms of relapse and/or mental health deterioration?

Personalised signs and symptoms included in the crisis plan	High risk or complex	Low risk or not complex	Total
Yes	10	44	54
No	11	49	60
TOTAL	**21**	**93**	**114**

In this area of work, a slight minority of the 'high-risk' cases have a crisis/contingency plan which includes personalised signs and symptoms of relapse and/or of mental health deterioration (11 out of 21 cases). For the 'low risk' group just over half do not have a personalised contingency plan (49 out of 93 cases).

Table 9 Does the crisis/contingency plan include specific personalised advice for the service user on what action to take in and out of working hours?

Crisis plan contains specific personalised advice	High risk or complex	Low risk or not complex	Total
Yes	20	88	108
No	1	5	6
TOTAL	**21**	**93**	**114**

In light of the previous table, it is a little surprising to find that nearly all the 'high risk' and the great majority of the 'low-risk' cases have contingency plans with specific personalised advice for the service users on what action to take if things go wrong in and out of office hours.

Table 10 Does the crisis/contingency plan include specific information for relevant others on what action to take in and out of working hours?

Crisis plan includes specific information for relevant others	**High risk or complex**	**Low risk or not complex**	**Total**
Yes	18	69	87
No	3	24	27
TOTAL	**21**	**93**	**114**

Table 10 is important as it can establish the extent to which carers, families and friends have been integrated into the contingency planning process. In three out of the 21 'high-risk' cases 'relevant others' are left out of the plan compared with nearly a quarter of the 'low risk' cases. It is possible, however, that in these cases there is no nominated 'relevant other' available or that the service user does not wish to nominate anyone.

Review of risk

Table 11 Has the risk assessment been updated appropriately e.g. due to changes/incidents or at least on a 12-monthly basis (for service users on CPA)?

Risk assessment updated appropriately or in the last 12 months	**High risk or complex**	**Low risk or not complex**	**Total**
Yes	18	63	81
No	2	29	31
Not applicable	1	1	2
TOTAL	**21**	**93**	**114**

The great majority of the 'high-risk' cases have had their risk assessment updated appropriately (18 out of 20 cases where this was applicable). This could be because risk factors change over time (sometimes from day to day) or that a period of one year has elapsed since the last assessment. Over two-thirds of the 'low-risk' cases have had their risk assessments updated appropriately (63 cases out of 92).

Table 12 Risk has been reviewed and noted at every Clinical Review for the last 3 sessions.

Risk reviewed and noted at every Clinical Review for the last 3 sessions.	High risk or complex	Low risk or not complex	Total
Yes	11	23	34
No	9	68	77
Not applicable	1	2	3
TOTAL	**21**	**93**	**114**

Half of the 'high-risk' cases have had their level of risk reviewed and noted at each of the last three Clinical Review they have attended (11 cases out of 21) compared with about a quarter of the 'low risk' cases (23 cases out of 93).

Care Planning/Intervention

Table 13 Does the Personal Support Plan (PSP) clearly show a description of the action to be taken and by whom?

PSP shows clear description of action to be taken and by whom	High risk or complex	Low risk or not complex	Total
Yes	21	93	114
No	-	-	-
TOTAL	**21**	**93**	**114**

The Personal Support Plan provided for every service user clearly shows a description of the action to be taken and by whom in every case irrespective of their level of risk. PSPs have been produced for all the cases in this sample irrespective of the risk they pose.

Table 14 Do the records demonstrate the planned interventions have been/are being carried out?

Records demonstrate the planned interventions have/are being carried out?	High risk or complex	Low risk or not complex	Total
Yes	19	91	110
No	2	2	4
TOTAL	**21**	**93**	**114**

In all but four cases across the whole sample, the records show that the interventions planned are being carried out or they have been in the recent past. The absence of the planned intervention was proportionately greater among the 'high-risk' cases (two out of 19) than among the low-risk' cases (two cases out of 93).

Table 15 Is there a clear description in the plan of planned interventions/rationale for interventions?

Clear description in the plan of planned interventions/ rationale for interventions?	High risk or complex	Low risk or not complex	Total
Yes	20	92	112
No	1	1	2
TOTAL	**21**	**93**	**114**

Again, there is a very high level of completion of the planned interventions and/or a written rationale for the interventions that have been proposed: 112 cases out of the 114 contain clear descriptions.

Evidence of variation between CDSs

One of the conclusions to be drawn from the preceding tables and discussion is that because there is little variation in completion of the assessments and plans in relation to the level of risk posed by the service users there can, therefore, be little variation in completion rates by CDS. There are instances where it can be useful to look at the variation practice across the Trust and all of these relate to Crisis/Contingency Planning.

The data presented below relates to only those standards that showed some variation in the preceding analysis.

Crisis/Contingency Planning

Table 16 Does the crisis/contingency plan include personalised signs and symptoms of relapse and/or mental health deterioration?

Personalised signs and symptoms included in crisis plan	CDS				Trust
	Brighton and Hove	Coastal West Sussex	East Sussex	North West Sussex	
Yes	16	16	12	10	54
No	10	22	11	17	60
TOTAL	**26**	**38**	**23**	**27**	**114**

In Brighton and Hove and in East Sussex CDSs, most cases had a crisis/contingency plan which included personalised signs and symptoms of relapse and/or mental health deterioration (16 out 26 and 12 out of 23 respectively). In Coastal West Sussex and North West Sussex CDSs, a minority of cases had such a crisis/contingency plan in place (16 out of 38 and 10 out of 27 respectively). Proportionately, the situation is slightly worse in North West Sussex than in Coastal West Sussex.

Table 17 Does the crisis/contingency plan include specific personalised advice for the service user on what action to take in and out of working hours?

Crisis plan contains specific personalised advice	**CDS**				**Trust**
	Brighton and Hove	Coastal West Sussex	East Sussex	North West Sussex	
Yes	26	35	22	25	108
No	-	3	1	2	6
TOTAL	**26**	**38**	**23**	**27**	**114**

There is little variation between the CDSs as to whether the crisis plan includes specific advice for the service user on what action to take in and out of working hours. Most of the contingency plans do contain specific advice for the service users on what actions to take in a crisis.

Table 18 Does the crisis/contingency plan include specific information for relevant others on what action to take in and out of working hours?

Crisis plan includes specific information for relevant others	**CDS**				**Trust**
	Brighton and Hove	Coastal West Sussex	East Sussex	North West Sussex	
Yes	20	33	16	18	87
No	6	5	7	9	27
TOTAL	**26**	**38**	**23**	**27**	**114**

There is greater variation between the CDSs when it comes to specific information on what action for relevant others to take in a crisis in and out of office hours. This information is not available in nearly one-third of cases in the sample across the Trust (29 out of 114). Completion rates for this item are lower in East Sussex and North West Sussex CDSs than in Brighton and Hove and Coastal West Sussex.

Review of risk

Table 19 Has the risk assessment been updated appropriately e.g. due to changes/incidents or at least on a 12-monthly basis (for service users on CPA)?

Risk assessment updated appropriately or in last 12 months	**CDS**				**Trust**
	Brighton and Hove	Coastal West Sussex	East Sussex	North West Sussex	
Yes	19	26	21	15	81
No	7	10	2	12	31
Not applicable	-	2	-	-	2
TOTAL	**26**	**38**	**23**	**27**	**114**

Across the Trust, risk assessments have been updated appropriately e.g. due to changes in the service users' circumstances or as the result of incidents or at least

on a 12-monthly basis when service users are on CPA when the case is either high risk or complex as can be seen in Table 12. In this Table we can see that some CDSs are better than others at updating risk assessments appropriately. East Sussex had the highest level of completions followed by Brighton and Hove, Coastal West Sussex, and then North West Sussex.

Table 20 Risk has been reviewed and noted at every Clinical Review for the last three sessions.

Risk reviewed and noted at every Clinical Review for the last 3 sessions.	**CDS**				**Trust**
	Brighton and Hove	Coastal West Sussex	East Sussex	North West Sussex	
Yes	9	8	11	6	34
No	17	27	12	21	77
Not applicable	-	3	-	-	3
TOTAL	**26**	**38**	**23**	**27**	**114**

The completion rates for risk reviews at each of the last three Clinical Reviews differ quite widely. Across the Trust, two in every three reviews had not been completed in this way but we also know that high-risk cases are not distributed equally across the CDSs.

Appendix E Follow-up study of the serious incident cases

In order to investigate the Trust's aim to have a robust SI 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. Our intentions were 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.

Trust processing of serious incident investigation reports

When dealing with an incident the Trust's response is governed by its Incidents, Serious Incidents and Learning from Deaths Policy and Procedure (policy number TP/RHS/158 v.6). This document defines serious incidents and sets out the process for ensuring consistency in grading incidents. The policy specifies who can carry out an SI investigation and sets a 60 working-day expectation from completion. The policy document also includes a report template which investigators are to use to present their findings. Investigators use a 'root cause analysis' methodology.

The report template covers issues including the identity of the service user, the nature and circumstances of the incident, something of the background of the service user, their care and treatment by the Trust, the Trust's response of the Duty of Candour, the finding of any care and delivery problems, a timeline of recent encounters between the service user and the Trust, any notable practice, any lessons learnt and recommendations for future learning by the Trust, how the report will be used within the Trust and its presentation to the service user's next of kin.

All incidents which potentially meet the serious incident criteria are received by the Governance Support Team (now the Clinical Governance Team) and each day a senior member of the Team reviews the incidents to decide if they meet the Serious Incident/Higher Learning Review criteria. The staff member uses the NHS England Serious Incident Framework and the Trust's own Serious Incident policy to make this decision. If this senior Team member is uncertain about the level (because of lack of detail in the initial incident form or as further information about the level of care being provided becomes available) then a discussion takes place between the GST/CGT and other senior staff. For most higher-level incidents, an Initial Management Review (IMR) is completed to establish an understanding of the details of the incident and to decide whether any immediate action needs to be taken by the team or the CDS.

Once a decision has been made on how to rate a serious incident (Level 1, 2 or 3), and if it has met the Serious Incident/Higher Learning Review criteria, by a senior member of the Trust its rating is then approved by the Deputy Chief Nurse. The Serious Incident Coordinator will then allocate the investigation to a team and a record is made of the date for the completed report/investigation to be returned to the GST.

A weekly serious incident status report is produced and updated centrally so that it can be seen clearly where each Serious Incident/Higher Learning Review is at that time; this information is shared weekly with Service Directors and General Managers.

When the draft report is submitted, an action plan is then written by the manager of the team where the serious incident occurred. Not all serious incident reports lead to recommendations and in those cases, there is no need to prepare an action plan. Where there are lessons learnt and recommendations there is a statement of the action required to accomplish the recommendation together with a completion date, the lead member of staff and their level of responsibility. Importantly, the form of evidence to be used to demonstrate completion of the action is also stated. The completed report is then signed off by the CDS and the GST/CGT. This approach has the advantage of ensuring that actions which have resource implications can be accommodated.

Each serious incident report and its action plan is then submitted to commissioners with the action plan being uploaded to the risk register (a central reporting system) and the individual actions are graded by severity (on a RAG system). Action plans include the CDS is responsible for implementing each action and because this is held centrally the GST/CGT can then track progress. Each month the GST/CGT sends out a report to CDSs on the number of actions still to be completed. The GST/CGT will request evidence from the team to permit closure of the actions.

A Serious Incident Scrutiny Group is then held with commissioners and NHS England where all the serious incident reports are discussed and feedback is provided. Once the commissioners and NHS England have agreed on closure, the final serious incident report is disseminated to the CDSs for sharing and implementing learning.

Other aspects of the serious incident process are described in Appendix G below.

Results of the follow-up study

The plan to analyse the SI investigations was to assure ourselves that the Trust had taken on board our recommendation. Initially, we received 38 sets of Level 2 SI 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 (this case has been exclude from the following analysis). All the tables below are based on 35 cases. Their demographic characteristics are set out in the table below, this way of displaying the information is adapted from the NCISH[4].

[4] National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (2017) Annual Report 2017.Univeristy of Manchester

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 years	5	8
>5 years	6	9
Behavioural features		
History of self-harm	7	8
History of violence	**	7
History of alcohol misuse	3	11
History of drug misuse	3	14
History of self-neglect	7	9

Note: ** fewer than 5 cases

The number of cases analysed is too small for any kind of statistical analysis and even presenting the data in the form of percentages would be misleading. The age range of the cases is restricted as being of working age was an inclusion criterion. Several factors listed are known to be risk factors e.g. the presence of social isolation as evidenced by the lack of close relationships in marriage or long-term relationships, living alone and having chronic physical health problems (in addition to long-standing mental health problems).

Twenty-four out of the 35 patients whose deaths were investigated by the Trust had been diagnosed as suffering from an affective disorder (low mood, depression or Bipolar disorder or anxiety disorder). Only six were diagnosed as suffering from

schizophrenia or another delusional disorder; three had a main diagnosis of personality disorder of some sort e.g. emotionally unstable personality disorder or antisocial personality disorder. The investigation reports mentioned that 21 had a secondary diagnosis although these diagnoses were not always stated clearly.

It was not always possible from the records, where information is available, to establish how long these service users had been in contact with mental health services generally or the Trust in particular. Eleven had been in contact for less than 12 months and this figure includes some who were awaiting assessment. Nearly half (15) had been in contact with services for five years or more.

This small group of service users experienced several behavioural features which increased the complexity of their presentations. Nearly half (15) were recorded as having a history of self-harm, 17 had a history of drug misuse, 16 had a history of self-neglect, 14 had a history of alcohol misuse and eight had a known history of violence. Not all these problems were currently present but many were and a number of the service users had multiple vulnerabilities. In a number of these cases there is no information about these issues and it is perfectly possible that these figures understate the incidence of these features. In some cases, this reflects the lack of knowledge the Trust had about individuals who had only recently come to its attention and for whom documentation was still being collected. In a handful of cases the service user was known to the Trust for a matter of hours e.g. an initial triage assessment was still being carried out when the service user left the venue and hanged them self or when the service user had been assessed and killed themselves while awaiting an appointment letter.

Table 2 Service characteristics of patients whose deaths were subject of serious incident reports by gender

Service users' contacts with mental health services	**Female (n=13)**	**Male (n=22)**
Missed last contact with mental health services	**	6
Last contact within 7 days of death	10	11
History of non-adherence to medication	**	8

Note: ** fewer than 5 cases

The data in this table suggest that most service users (21 out of 35) had contact with mental health services within seven days of their death. There were problems of non-engagement with services but this applied to only a minority of these cases. Fewer than 10 had missed their last arranged appointment with services. Most of the female service users and half of the males had had contact with mental health services within the seven days preceding their death. Fewer than 15 of the service users were known to have had a history of non-compliance with the medication prescribed for them. These figures may be an underestimate as the issue might not have seemed relevant to the investigator.

Recommendations made in SI investigations

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 SI investigation report found care and service delivery problems that needed to be addressed in the future, there were five 'no recommendation' cases here.

The most frequently reported category of recommendations related to 'Practice/Documentation of Risk', examples are:

- Risk assessment and care plan to be updated following changes in a patient's risk profile.
- The Mental Health Rapid Response Service should consider the introduction of a triage scale to support clinical decision making and ensure that risk factors are identified.
- Team to consider the requirements of risk assessment documentation for patients on standard care and specifically in the case of psychiatrists who document this in a clinic letter.
- Clinical entries will evidence non-engagement in line with Trust 'Difficult to Engage/DNA Policy'.

'Policy management' included:

- As directed by Trust policy, CPA reviews will evidence the contribution of all involved services.
- All staff to follow the Trust's Safeguarding Adults Policy to ensure patients who are vulnerable to neglect are safeguarded.
- Liaison team to screen for patient's current status with Community Teams prior to confirming follow-up plan.
- Neurobehavioural Service to consider ways of addressing the long waiting list for an attention deficit hyperactivity disorder (ADHD) assessment.
- In-patient services and Crisis Resolution and Home Treatment team (CRHTT) to work together to tighten up systems to ensure arrangements are in place for medication when patients are on section 17 leave and on discharge, and the drug chart is up to date and available for when the leave period starts to avoid risk of medication errors.

'Communication' recommendations included:

- Service to review current communication and available support for psychiatrists and psychologist for wider MDT including opportunities available in cluster meetings and seminar groups.
- CRHTT and ATS to review the way they communicate the outcome of their input, ongoing risks and recommendations for ongoing support to ATS when patients are ready for transfer back to ATS.
- Any change of medications or medication should have evidence that the GP was notified.

- Service users will be informed of decisions made about their care via correspondence and/or telephone.
- Street Triage practitioners to communicate all contacts with patients and carers to the appropriate mental health team.

'Pathway development' included:

- Patients should be offered a medical review following disclosure of an overdose.
- The importance of Trust staff to consider referring to the GP for anti-depressants and not a consultant psychiatrist.
- Guidance in relation to follow-up of patients who have declined further services following presentation in A&E should be included in relevant Trust policies.
- Importance of adhering to the shared care protocol for prescribing medication for ADHD, and that where best practice guidelines are not followed the rationale and decision-making process for non-adherence should be followed.
- Teams to give consideration and document discussions in relation to bereavement counselling where clinically indicated.

'Training' included:

- To offer individual supervision and reflection to the lead practitioner to ensure that they are adequately supported to consider the learning from the investigation.
- Team leaders to revisit clinical policies with teams during team meetings or to consider encouraging supervisors to include discussions of relevant policies in supervision.
- Clinicians need training and education about the Active Engagement policy and how to implement this effectively in day-to-day practice.
- To ensure that the training for new junior doctors on rotation with the service addresses clinical standards in relation to report writing and the sharing of information. Junior doctors to be made aware of their responsibilities not to send discharge reports to GPs with incomplete information about medication.

'Organizational (sic) learning' included:

- The Trust should satisfy itself that practice in this area particularly in respect of Mental Health Liaison Teams conforms to stipulated standards and these standards should be reviewed and developed in line with the learning from this report.
- Learning from this SI review should be fed back directly to the discharging X care team.

'Contact with families' included:

- Services to identify opportunities for liaison with families.
- Guidance provided when a service is notified of an untoward patient death should emphasis the Duty of Candour responsibilities even when the patient

has been discharged. Staff should feel supported to undertake roles and actions associated with the Duty of Candour.

- ATS will offer carers a carer's assessment.
- Improve carers' engagement and their contribution to care planning (implementation of Triangle of Care).
- Staff follow Trust policies regarding family and carer engagement, and practice within the principles of Triangle of Care.

Because the numbers of cases and recommendations differ from the data presented to the Trust and NHS England in 2016, we decided to rank the topics contained in recommendations. The order of the recommendations in the two reports is broadly similar, as seen in the table below.

Table 3 Ranking of recommendations made in Trust's SI reports and the Thematic Review of Homicides

Topic of recommendation	**Ranking order of recommendations made in reports subject to the Thematic Review of Homicides**	**Ranking 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

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 theme reflects what the Trust reports regularly in the Integrated Performance Reports which are presented to every Board of Directors meeting.

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 such policies were not followed in 24 of the 36 cases though none amounted to a root cause.

The 31 cases where there were one or more recommendations were then tracked through the process described above and in Appendix G below. In a small number of cases, actions had been completed before the action plan had been signed off. The majority were completed within the timescale set out in the action plan. The actions which took longer than planned were invariably those which involved writing new Trust policies or where there was some form of inter-agency cooperation needed.

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.

Appendix F Duty of Candour

The introduction of a statutory Duty of Candour as CQC Regulation 20 in November 2014 following the Francis Report[5] places a requirement on providers of health and adult care services when things go wrong. The regulation is intended to ensure that service providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf in relation to care and treatment). The Duty of Candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

At the start of any 'root cause analysis' serious incident review, the Trust's policy sets outs a duty to ask families/carers if they wish to be involved in the review. Decisions are then made to establish the level and type of involvement; which member of staff will link with the family/carers. Families/carers are invited to ask questions about the care and treatment given to the service user and are asked how they would like the outcomes of the investigation to be fed back to them.

If the serious incident is highly complex as in the case of an inpatient death or a homicide, a senior member of staff will act as a Family Liaison Lead and be a bridge between the family/carer and the serious incident investigator. This did not apply to any of the 35 serious incident cases we analysed as they did not meet these criteria.

The initial conversation with the patient and/or their carers and family should occur as soon as possible – meaning within 10-working days after the Trust becomes aware of the incident. Staff making contact need to consider issues such as the clinical condition of the patient; and issues such as the availability of the patient and/or their families and carers, and the availability of additional support e.g. an interpreter, independent advocate or a chaperone.

The initial contact should then be followed with written confirmation of the conversation; again, within the 10-working days limit.

Complying with the Duty of Candour provides several problems for mental health trusts as some patients have complicated relationships with their families/carers and may not have shared information about their families/carers. Relationships with families/carers may have changed over time and service users may not have updated contact details. Also, some service users in the community may have infrequent contact with services and those dealing with an unexpected death may not know that the person was a mental health service user. Some may have ceased all formal contact with mental health services either because they have been discharged or because they have disengaged from contact.

The information we have brought together on these 35 cases reflects the sometimes complex relationships between the individual and their families/carers. The table below seeks to portray the lengths to which the Trust has to go to satisfy the Duty of Candour. Information about the existence and whereabouts of families/carers (formal

[5] Mid Staffordshire Foundation Trust Public Inquiry chaired by Robert Francis QC. Report published in 2013

legal next of kin). In some instances, third parties such as GPs or probation officers may have this information but may be precluded from sharing it with a trust because of rules about confidentiality. HM Coroners may discover next of kin details in preparation for an inquest and will then share the information with a trust. All this takes time, and some next of kin in this sample complained about the delay in the Trust informing them of the service user's death. The Trust complied with the 10 working-day 'rule' in all the cases except the one where no next of kin has ever been identified.

Table 1 The Trust's compliance with the Duty of Candour

Trust's knowledge of next of kin	**Duty of Candour and Participation in serious incident Process**	**Number of cases**
Next of kin known to Trust from case records	Condolences and support offered but next of kin did not participate in SI process	10
	Condolences and support offered and next of kin participated with comments, questions, compliments and/or complaints about care and treatment	19
Next of kin not known to Trust but traced through HM Coroner	Condolences and support offered but next of kin did not participate in SI process	5
	Condolences and support offered and next of kin participated with comments, questions, compliments and/or complaints about care and treatment	0
Next of kin never traced or no known next of kin		1
Total		**35**

Although we did not make any recommendations about the Duty of Candour, this has grown in importance subsequently. We added the topic to the project proposal as we knew it would be integral to our investigation of the sample of serious incident cases. We have also collected information from several sources including the CQC inspection report and the Trust's own internal monitoring.

In June 2018, the Trust Board received a 'Serious Incident Annual Report' from the Quality Committee stating that in 2017/18 there was a total of 143 serious incidents that met the Duty of Candour regulation criteria[6]. In 11 of these cases there was a potential breach of the regulation. In four cases, there was a delay in contacting next of kin; in three cases, there was no next of kin; in two further cases the next of kin

[6] For full details see CQG guidance, Duty of Candour

did not respond to the Trust's attempts to make contact; in one case there was a delay in obtaining details of the next of kin from the coroner; and in one case, the service users had only been a service user for one day prior to their unexpected death.

The CQC reviewed five serious incident investigations where people who used the service had died unexpectedly. The serious incident reports were scrutinised to ensure that the Duty of Candour requirement was met.

Appendix G Trust Board, Committees and Meetings dealing with serious incidents

Board assurance and the Trust's committee structure

It can be seen from the organisation charts in Appendix K that the Trust's committees and boards fall into two major groups – those concerned with governance issues and those that are operationally based. This appendix describes the remits and activities of each of these committees as a background to the analysis of their effectiveness in the section of the report on Recommendations 1 and 3.

The Board of Directors 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 more detail below both in the commentary and in the tables of membership of the committees and panels.

The Board of Directors' agendas are always divided into six major sections:

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

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.

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

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.

The agendas for Board meetings always include a section on quality as one of the standing items for reporting and discussion. (Organisation charts for the Trust are provided below in Appendix I.) In addition, the Chief Executive (CEO) always includes a reference to SIs in her report which includes references to the work of the Executive Assurance Committee where a Serious Incident Assurance Report is discussed at each meeting. The CEO also summarises a report of the Quality Committee meeting.

The Board has reviewed the terms of reference etc for the Quality Committee twice since the publication of the Thematic Homicide Review.

Trust processes below Board level – operational

CDS Quality Assurance Panel

Each month, each of the CDSs prepares a quality assurance report. These reports include charts and a dashboard prepared by the clinical care intelligence team.

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

CDS Quality Assurance Meeting

Each quarter, each CDS attends a quarterly review meeting. This is the opportunity to review the quality and performance, their financial situation and progress towards meeting the annual objectives of the CDS in detail. The meeting is attended by the COO, the Performance Director and/or the CEO and the Chief Nurse as well as various support series representatives including Finance and HR. Information from both these bodies is used to produce the assurance report for the Executive Management Committee and the Trust Board.

Operational Management Board

The Operations Management Board meets (monthly) and receives reports from each of the eight CDS boards as well as from the CDS Quality Assurance Panel (which meets monthly) and the CDS Quality Assurance Meeting which meets quarterly. The CDS Quality Assurance Meeting then reports to the Operations Management Board

chaired by the Deputy Chief Operational Officer which discusses any open actions from serious incident investigations.

The OMB receives reports as part of its quality remit on topics such as trends in the use of Section 136 detentions across the Trust in each quarter.

The OMB reviews the ongoing register of organisational risks for each month which shows the ongoing risks by risk rating, which is coded on a scale of extreme, high, moderate and low. Ongoing risks are also shown in terms of when the next review date to check on completion has been set so that it is possible to see how long ongoing risk remain open. Finally, there is a visual display of named owners of ongoing risks. These organisational risks include some of the issues recognised in the Thematic Homicide Review, e.g. unallocated cases or the absence of up to date appropriately recorded risk assessments recorded on Carenotes.

The OMB receives a list of Open Serious Incident Action Plans which covers:

- Themes for Open Actions where risk assessment is usually the largest single category followed by communications, clinical policy development, training issues and clinical record keeping.
- Individual action plans which are colour coded in terms of priority, each entry includes a description of the serious incident together with each recommendation (if there is more than one), the action required and a statement of progress, the target date for completion of each recommendation and progress to date.
- Each record identifies the action plan owner, the date of the incident, the author of the serious incident investigation report, the team or ward, the setting of the incident, the CDS and the Directorate.

It is apparent that while recommendations may appear straightforward, they can require several actions which may require changes to Trust policies and procedures or discussions with various parts of the organisation to be implemented, or the development of business cases for policy changes, or staffing levels may not permit the necessary changes. Some recommendations may also involve third parties such as GPs or local acute Trusts. Cases which are awaiting closure or have been closed by the CCG are also identified.

Executive Management Committee

The Trust Executive Management Committee receives a Serious Incident Assurance Report at its meetings. For example, the January 2019 meeting received an overview paper on the Serious Incidents reported by the Trust during the preceding month together with immediate actions taken. The paper contains learning from all incidents, including serious incidents, action plans to bring together and highlight key themes. It also outlines the Trust's performance in relation to completion of serious incident investigations within the appropriate deadlines with summaries of the completed investigation reports which had been submitted to the commissioners during the period. The aim is to provide assurance to the Board that the root causes have been identified and lessons learned.

The Serious Incident Assurance Report contains the following types of information:

- The number and type of serious incidents reported to commissioners (CCG) during the month
- Trends in the number of serious incidents reported by the Trust since April 2016
- The number of serious incidents resulting in a fatality reported by the Trust since April 2016
- The number of fatalities reported by cause in the month
- Serious incident investigations submitted in the month within the deadline by CDS and the reason for the delay if there was a delay
- The percentage of serious incident reports submitted to the commissioners on time since April 2016
- The number of overdue serious incident reports by the level of investigation and by CDS
- Trends in the number of overdue serious incident actions for each month since January 2018
- A review of serious incident actions by priority level – high, medium and low
- Duty of Candour compliance report for the month
- CQC/Health and Safety Executive investigations
- NHS England Homicide Investigations
- Key themes, learning and actions, for example:
  - ❖ Scrutiny of a percentage of closed action plans to ensure the quality of the evidence supporting the completion is robust; a re-visit to the Service between six and 12 months later to ensure that changes have been embedded into practice, and the introduction of guidance on making actions SMART
  - ❖ A programme of learning events on topics such as 'safeguarding children' and 'physical health and learning from deaths (mortality)'
  - ❖ A programme of learning events following the Collaborative Review of Unexpected Inpatient Deaths
  - ❖ Three bespoke workshops on maintaining sexual safety on inpatient wards following an incident
  - ❖ A report on the progress of the work of the Lead Clinical for Risk Assessment Training
  - ❖ The development of an edition of the 'Clinical Message of the Month' on clozapine to support Learning from Deaths.

Clinical Governance Team

A monthly workshop occurs within the Clinical Governance Team to discuss SIs and to ensure consistency of grading of serious incidents in terms of the seriousness of the harm caused.

Comprehensive Level 2 investigations will be signed off by the Deputy Chief Nurse and either the Service Director or the Clinical Director with the final report and sign off is completed within 60 working days.

In certain circumstances, it is acknowledged that it may be difficult to complete the final report within these timescales. For example, enforced compliance with external

agencies timetables such as the police or HM Coroner; the investigation is highly specialised or multi-organisational, or the incident is of significant complexity.

The aim of a serious incident report is for individuals and the organisation to learn, so it is important for the final report to be shared with the team providing the care and treatment. 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 recommendations made. Any action plans for Trust-wide recommendations will be shared with the Deputy Chief Nurse and managed through the appropriate Trust-wide forum or committee.

Completion of the action plan is monitored by the responsible CDS with completion reported and evidenced through the Ulysses system. The General Manager has responsibility for closing completed actions on the risk register which is accessible through the Ulysses system.

The Deputy Chief Nurse, the Service Director and the Clinical Director for the relevant CDS are responsible for ensuring learning from incidents is shared with the staff of all grades across the Trust. This will be achieved through various ways including:

- by involving the family/carers in the serious incident investigation process;
- all templates used for incidents, regardless of severity, ensure that the causes of incidents and actions taken are systematically recorded;
- the whole system of reporting, investigating and sharing of incidents is designed to improve the quality and safety of services;
- the incident dashboard on the Ulysses system allows the sharing of collated incident reports. This helps to identify themes and trends within specific care setting such as a ward, a service or a CDS;
- individual staff through supervision/reflective practice will be encouraged to reflect on incidents and serious incidents which have occurred within their team;
- by producing a monthly Mortality Board report;
- by producing a quarterly Quality and Safety report and an annual Serious Incident Report.

Since January 2018, the Trust has published a quarterly report – Learning from Deaths – to comply with the expectations created by the Mazars report (2016).

A monthly internal scrutiny group chaired by the CEO has been established to ensure consistency, transparency and quality of the investigations of unexpected natural deaths and serious incident root cause analysis investigations.

Since January 2019, the CGT 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.

Trust processes below Board level – governance

Serious Incident Review Meeting

The Serious Incident Review Meeting is co-chaired by the Chief Nurse and the Chief Medical Officer. The meeting is held weekly and is presented with a spreadsheet of the week's Serious Incidents and Immediate Management Reviews (Level 1). Its main functions are:

- to inform the executive team of all serious incidents that have occurred in the previous seven days
- to appraise the initial management reviews from the previous week's SIs to review the level of investigation to ensure that it is proportionate to the incident and its potential learning
- to decide if the serious incident investigation requires a panel review or if an external view or review is required
- for some incidents, this meeting may contribute to the Terms of Reference of the review
- to identify/be aware of any immediate actions that have not already been identified through the Initial Management Review
- to consider any further support/guidance for the staff or the team involved
- to consider if there should be any involvement from legal services.

Serious Incident Scrutiny Committee

The Serious Incident Scrutiny Committee chaired by the CEO meets monthly and it functions to ensure consistency, transparency and quality of the investigations into unexpected deaths and serious incidents Root Cause Analyses[7]. Up to three significant serious incident reports are presented, minutes are taken and an action log put in place which is revisited every meeting.

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

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 were downgraded and 34 were closed or conditionally closed. There were no independent investigations commissioned in that quarter.

Serious Incident and Mortality Grading Assurance Workshop

A monthly Serious Incident and Mortality Review Grading Assurance Workshop is held in which all senior staff who grade the Serious Incidents and Mortality Reviews meet to review the grading and to act as appropriate.

[7] Root cause analysis using five whys

Safety Committee

The Safety Committee meets bi-monthly and its remit is to:

- critically scrutinise and understand all aspects of safety including strategy, delivery and clinical governance
- understand themes and trends in order to identify areas of good practice and areas of potential concern that require greater scrutiny
- recommend workstreams which will lead to improving safety and disseminate good practice
- understand and interpret new national guidance and how this will impact on the safe delivery of services.

Carers attend Safety Committee where serious incidents are reported. A service user was to start attending in July 2018.

The Committee receives a quarterly Quality and Patient Safety Report which includes materials on SIs among 33 other items of information e.g. Patient Safety Incidents, Duty of Candour, Anti-ligature audits. The Committee has information on the number of SIs reported to the CCGs each month since April 2016, the impact of serious incidents (degree of harm), whether the incidents took place in the community or in hospital, the number of SIs by CDS as well as by type (such as unexpected death, self-harm, AWOL etc). Similar information is also provided for serious incidents where there was a fatality.

The Report also includes information about the action plans developed in response to the recommendations of the serious incident investigations. Data are presented on the number of closed serious incident action plans, the number of open serious incident action plans and the number of overdue actions by CDS. A graph is provided on the number of overdue serious incident actions since April 2017.

There is information on the themes of action plans submitted to CCGs between 1 October 2017 and 30 September 2018. Then the information is provided on any Trustwide changes to practice and/or actions taken as a result of serious incidents. In Quarter 2, there was an issue of Patient Safety Matters, two Patient Safety Event 'Learning and Improving' workshops on 'Risk and Risk Assessment' and one on 'Safeguarding'. If an action applies to one or more CDSs that is also listed. This Report is also one of the places that any Reports to Prevent Future Deaths (Reg 28 of the Coroner's (Investigations) Regulations, 2013) are reported.

The Safety Committee also produces a Serious Incident Assurance Report for the Quality Committee which provides an overview of the SIs reported by the Trust during a month together with immediate actions taken. It contains the learning from serious incidents, including serious incident action plans as a consequence of the incident/review, in order to highlight key themes. It also outlines the Trust's performance regarding the completion of Serious Incident Investigation Reports within the appropriate deadlines and summarises the serious incident Investigations completed and submitted to commissioners during this period. This is to provide assurance to the Trust Board that the root causes have been identified and lessons learned.

The Serious Incident Assurance Report includes reasons for serious incident final reports not being submitted to the commissioners within the deadline and it includes details on the CDS responsible and the type of incident.

The report also has details of the priority rating given to serious incident action plans (high, medium, or low). Monthly automatic reminders are emailed to open serious incident action plan owners both to support CDSs in reviewing and auditing the process, and to close serious incident action plans in a timely manner. In addition, a monthly Open Serious Incident action plan report is sent to the Chief Operating Officer, Deputy Chief Operating Officer, Service and Clinical Directors which can be used to inform discussions at CDS clinical governance meetings.

The Committee also receives (occasional) thematic reviews of serious incidents. In March 2019, it received a report on serious incidents in the community where 'Active Engagement or Did Not Attend' was noted as a lesson learned for care or as a care and service delivery problem in 16 out 49 recent serious incident cases. The report put DNA in the context of research and other evidence about the risk such behaviour poses to service users' safety. The Trust's DNA rate was 12%. A brief outline of each case was provided and information was given on the relevant action plans. The paper then drew up a list of recommendations and implications for practice which could be taken forward into the Trust's Active Engagement/DNA policy review. A Trust-wide audit of DNA is to be completed in the 2019/20 clinical audit cycle.

Quality Committee

The newly re-formed Quality Committee (2017) receives a monthly Serious Incident Assurance Report, a Quality and Safety Report and a Learning from Deaths Report. The Quality Committee also receives information about 'Positive Practice', and 'Effective Care and Treatment'.

In 2017, the Trust Board set up sub-committees below the Quality Committee where discussions and action can take place. These sub-committees review how the Trust uses resources responsibly and efficiently, and how they link into other work and productivity. The Trust Board used the CQC Key Lines of Enquiry to inform the workstreams of each sub-committee.

The sub-committees report bi-monthly to the Quality Committee, and they can escalate or note issues that are required to be raised through summary reports. A Quality Committee summary is then produced to update the Board of Directors. This is intended to ensure that all reports are streamlined and received through the Quality Committee before being submitted to the Board of Directors. The purpose of the Quality Committee is to enable the Trust Board to obtain assurance that high standards of care are provided by the Trust that is safe and effective. The Committee also seeks an understanding and awareness of the critical factors that impact on quality and safety across the Trust.

The Committee receives exception reports from:

- The Safety Committee
- The Effective Care and Treatment Committee
- The Positive experience Committee
- The Mental Health Act Committee.

In addition, it receives assurance reports on:

- The Patient Flow Quality Impact Assessment
- Quality and Safety Review updates
- Sexual Safety Work plan progress report
- Serious Incident Report
- Monitoring the Mental Health Act Annual Report
- Physical Health Annual Report
- The Quality Account
- Safer Working Hours.

A standing heading refers to the Serious Incident Assurance Report and topics of concern are highlighted. An annual report on Serious Incidents is presented by CDSs.

Appendix H Evaluating the impact of education and training

Evaluation of clinical risk e-Learning package – pilot study

Aims of the study were to:

1. "Evaluate the effect of the E-Learning Risk Training and reflective practice sessions in terms of knowledge and understanding its application to clinical practice within three months of completing the training.
2. Consider the E-Learning Risk Training from a peer trainer perspective."

The specific evaluation questions were:

1. "What evidence can the practitioners interviewed provide to demonstrate how the E-Learning Risk Training influenced their practice?
2. What evidence can the peer trainers interviewed provide to demonstrate how the E-Learning Risk Training might reflect needs of service users?
3. Identify any barriers to the training learning outcomes being integrated into practice by the participants."

The findings are based on structured telephone interviews of a small number of respondents – seven practitioners and three peer (service user) trainers. The interview questions were based on the aims, learning outcomes and content of the training and used Kirkpatrick and Kirkpatrick's (2006) framework as a guide.

The recommendations in full are as follows.

"E-Learning

"Historically, face to face training was the norm for risk training and consideration needs to be given to whether or not e-Learning should be the main mandatory teaching approach to Risk Training supported by face to face training which is still in the process of being re-established across the Trust. The peer trainers and practitioners all had views on this approach to learning about risk; from the extreme of some not remembering any of the content (practitioners) to those that valued parts of the training which included the scenario and quiz (peer trainers). In the main, face to face training was appreciated as a positive method of learning, therefore the inclusion of reflective practice sessions in the CDSs would be a valuable way forward to complement e-Learning and would more effectively support the importance of improving skills and changing behaviour which is more challenging to do and evaluate through e-Learning alone. There is a decision to be made about whether these sessions should be part of the mandatory requirements.

"For clinical practice

"Recommend:

- The availability of simple guidance for teams on risk assessment including protocols where these do not already exist.

- Clearer support for practitioners in implementing the training – in particular local case discussion with an explicit focus on risk assessment and procedures.
- The development of explicit mechanisms for sharing learning in teams – including when the worst does *not* happen, so learning from good practice and outcomes.
- The use of clinical supervision to address risk issues routinely.

"For the Training

"Recommend:

- That Risk assessment training and policy need to be even more clearly linked.
- Team training include opportunities for reflective practice.
- Service user input into the training including input into a review of and further developments of the e-Learning training.
- That the current e-Learning training is reviewed based on the recommendations – though giving clear consideration to the positive gains from using e-Learning.
- That the training ensures a focus on family and carers.
- Clinical supervision and reflective practice is used to address the theory-practice gap – with signposting in the training to use clinical supervision in this way.
- Include links to outcomes of audits that are risk related to the risk training.
- Once the roll out of the face to face training is done, this may provide another opportunity to examine the impact of the overall training on practice.
- Include reference to serious incident reviews as part of any training provided.
- Separate e-Learning for HCAs and registered practitioners to acknowledge the differences required in knowledge and understanding to practice.

"Future evaluations

"The following are recommended:

- The overall impact on service user care should be viewed as a separate evaluation; for example, the service users' experiences of being risk assessed.
- A future evaluation study should be considered in order to measure practitioner skills through the examination of risk plans produced before and after any risk training.
- Involvement of the audit team – even though this was not classed as a clinical audit, the positive impact of education and training on practice and the service user experience is crucial and therefore the expertise of the audit team and with this the opportunity to sustain this kind of evaluation work is proposed.
- As a university Trust, with a number of clinical academic posts which support strong links to a number of university partners we should be encouraging staff who are doing masters level education to lead on these kinds of evaluations.

- There will be a need for an audit of risk plans once the training has been reviewed and revised.
- Once the training is reviewed and revised, the need to audit how this actually impacts, for example, the implementation of risk plans particularly new additions to the training – having the family more involved in the risk assessment. This will capture the review comment about risk assessments not completed or practitioners not using information from family and carers effectively.
- In order to have an accurate recording of attendance at any training that is supplementary to the e-Learning, attendance sheets need to be kept with some way of accurately recording locally on MyLearning. Aims and learning outcomes should be provided that can then be referred to for future evaluations.
- It would be helpful to have a researcher involved with the teams who put together action plans that identify pieces of work that include the use of research methodologies and methods in order to set realistic timelines and objectives that can be successfully managed and achieved."

Team development days (TDDs)

The video sets out principles of TDDs:

- Teams working together support each other, reduce staff stress and injury.
- TDDs are interactive, with teams listening to each other and thinking together.

The focus of the days is on:

- reflection and learning from all aspects of their work
- keeping the service user at the centre of their work
- creating time together, agreeing goals and assessing performance against those goals.

The Trust is starting to include carers and service users as part of the wider team – which helps the team focus on what is important and breaks down any barriers between service users and carers on the one hand and staff on the other.

MyLearning

This is the Trust's learning management system. Guidance and support on using the system are disseminated to staff within the Trust through:

- induction – when staff are set up with access
- Education and Training Roadshows around the Trust
- dedicated pages about the MyLearning system on the Intranet.

Functions of this system include:

- sending email reminders to staff when specific training is due
- central facility for staff to book e-learning and face-to-face training

- staff log supervision and appraisals
- an individual learning log for each member of staff
- access for line managers to monitor their individual staff's completion of training.

Preceptorship programme

The content of the 14 study days which are part of this programme include:

- An introduction to the preceptorship programme
- Working in partnership with service users and family, friends and carers
- Clinical supervision
- Service provision, change process and leadership
- Work-life balance, teamwork and developing resilience
- Conflict resolution
- Domestic and sexual violence
- Suicide prevention
- Medication management
- Learning Disability
- Physical health
- Reducing restrictive practices.

Education Quality and Performance half-year report (August 2018)

This report states that the standards are stretching and designed to lead to programme of improvement. The report provides the baseline achievement against which progress can be tracked in January 2019.

Statement of Intent 7[8] Provision of training required for staff to deliver effective care, support and treatment

STANDARD 7.1: Compliance of 85% with each of 24 core mandatory training courses, in every team

The Trust is 87% compliant across the core mandatory and 81% for the 24. The Trust has agreed a target of 85% for all courses and all teams.

STANDARD 7.2: Core mandatory training coverage aligned to core skills framework (Skills for Health)

All core mandatory training subjects have been aligned.

STANDARD 7.3: Training needs analysis (TNA) conducted for delivery of menus of care and interventions designed by each Clinical Academic Group, and annual training plan designed in response to this TNA.

[8] These statements of intent and standards are numbered according to the numbering scheme for the statements of intent and standards overseen by the Effective Care and Treatment Committee (ECAT) - which include other standards not related to education and learning

The Annual Training Plan (ATP) is developed and circulated following confirmation of available funds from HEE KSS. Developmental training is identified through a process of matching operational needs and objectives with individual interests and aspirations. These are identified through the appraisal process and escalated for approval through the CDS.

STANDARD 7.4: Trust policy and practice protects time for all required training.

The 'Mandatory Training and Induction' policy states that adequate provision is made for mandatory training and induction, including via e-learning.

STANDARD 7.5: Training opportunities available for all occupational groups included in annual training plan.

The ATP divides all available funding proportionate to staff groups and Care Delivery Services. A training programme for admin and clerical is in development.

STANDARD 7.7: 100% of staff in posts requiring registration can evidence registration is up to date and in place.

All staff are registered in the Trust's learning management tool (MyLearning), but only nurses are required to evidence revalidation on the system. Staff should provide this evidence at each appraisal, but the Trust is not able to report on this effectively at present.

STANDARD 7.8: Volunteers and bank staff have training requirements clearly specified and achieve 85% compliance.

All staff, including volunteers and bank has access to all training solutions required for them to complete their job roles.

STANDARD 7.9: Staff have fair access to training opportunities irrespective of protected characteristics.

The ATP sets the framework for fair access to training based on strategic service need. The Trust monitors the fair distribution of funded training and no concerns about fairness have been raised through our own self-assessment or the equality and diversity team's review of data. However, they concluded that discrimination could be hidden in the data and further analysis was required.

Statement of Intent 8 Provision of high quality educational and practice learning opportunities for future workforce

STANDARD 8.1: The Trust's medical, nursing, psychology, psychological therapy, OT & AHP, and new roles programmes will meet student satisfaction criteria defined by each professional or registering body/programme.

8.1.1 Nursing and paramedic future workforce

The Trust reviews all student feedback on practice learning opportunities; this is sent to the Nurse Education Team via their higher education partners.

8.1.2 Medical future workforce

The Trust has improved regionally across HEE KSS 1st place in 2018. They have improved in overall satisfaction for the 4th year and are currently 5% points in front of the second-best Trust.

8.1.3 Pharmacist and pharmacy technician workforce

Feedback on pre-registration pharmacist placement content and learning experience is received as detailed below. The Trust currently provides short-term (one week or two week) mental health experience placements to pre-registration pharmacists undertaking their clinical training. Placements are usually evaluated as providing a positive and valuable experience.

8.1.4 Psychology and psychological therapies future workforce

The Trust can evidence strong performance for student satisfaction among clinical psychology doctorate students, interns and undergraduates, but needs to track this more systematically for psychological therapy trainees on placement. The Trust hosts trainee clinical psychologists who complete feedback and audit forms: results have been largely positive.

8.1.5 Occupational therapy and allied health professions future workforce

The Trust collects feedback on all placements, which is sent to the practice administrator who picks up any issues and feeds it back to the practice educator, to address.

8.1.6 New roles: Peer Support Specialists

In 2017/18 the Trust launched its Peer Strategy co-produced with the current Trust peer workforce, this identified the need to strengthen the supervision and CPD opportunities available to peers, which is ongoing.

STANDARD 8.2: Working in partnership with Universities to develop and deliver the education programmes required to deliver the expanded mental health workforce required by the Five-Year Forward View of Mental Health.

8.2.1 University of Sussex Partnership Programmes

The Cognitive Behavioural Therapy (CBT)/Improving Access to Psychological Therapies (IAPT) programme increases capacity for IAPT service expansion and increasing access to CBT in other mental health services, as required by the 'Five-year forward view for mental health'[9] (5YFVMH).

Mental health practitioner programme delivers a new workforce to assist delivery of the 5YFVMH expansion in mental health services, in the context of shortage in registered occupations.

[9] Five-year forward view for mental health (2016) A report from the independent Mental Health Taskforce to the NHS in England.

A programme delivers the Children's Wellbeing Practitioner competences as required by CYP IAPT as part of the 5YFVMH.

8.2.2 Cognitive-Analytic Therapy (CAT)

CAT is part of the suite of therapies that can helpfully increase capacity in order to meet the 5YFVMH aim of increasing access to psychological therapies for people with severe mental health challenges.

8.2.3 Mindfulness-based training

MBCT is part of the suite of interventions now offered by IAPT as part of the 5YFVMH plans. The quality of the training delivery from 2017 was rated as 'good' or 'excellent' (mostly 'excellent') on every one of the 11 training days by every trainee who completed the feedback forms.

8.2.4 Family Interventions Training[10]

The Trust continues to offer a successful family interventions course in partnership with Surrey University and will continue to work to support FI graduates to practice family interventions within their roles.

Statement of Intent 9: Delivery of public education that is co-produced and supports wellbeing and recovery

STANDARD 9.1: The Trust will ensure that recovery college courses meet fidelity criteria for student choice, co-production and co-delivery.

All aspects of the College and its courses are co-designed and co-produced by experts by personal experience of mental health challenges alongside experts by professional training. The Trust currently lacks a process for reviewing fidelity of every course to the recovery college model.

STANDARD 9.2: 'Make your Mark' to deliver arts and health programmes that reduce stigma, improve engagement in the arts and improve wellbeing for people with mental health challenges and staff.

This is the arts and health programme for the Trust and has delivered two major arts projects. The programme completed a longitudinal evaluation of arts-based Recovery[11]. No previous studies have evaluated arts-based recovery college courses. Yet arts may assist in personal recovery, as often defined by service users, through social connection and personal meaning. This interdisciplinary study evaluated (i) whether self-reported wellbeing and arts activities increased following arts-based recovery college courses, and (ii) how students, peer trainers and artist-trainers understood courses' impact. The design was mixed methods. Of 42 service

[10] F1 refers to Foundation Year 1 which is the first year of the two-year programme for doctors who have just graduated from medical school. It allows them to prepare for practising as a fully registered doctor in the UK.

[11] Report published in June 2018.

user students enrolling, 39 completed a course and 37 consented to provide data. Of these, 14 completed pre and post course questionnaires on mental wellbeing and 28 on arts participation. Post course focus groups were held with six of eight peer trainers and five of seven artist-trainers, and 28 students gave written feedback. Twenty-four students were interviewed up to three times in the subsequent nine months. There were statistically significant increases in self-reported mental wellbeing and range of arts activities following course attendance. At follow-up 17 of 24 students reported improved mental wellbeing, while seven reported little or no change. Some spoke of increased social inclusion and continuing to use skills learned in the course to maintain wellbeing. Initial in-course experience of 'artistic growth' predicted follow-up reports of improvement.

Recommendations

- A named lead will be agreed for each standard who will be responsible for expanding on and delivering the maintenance/improvement plan for that standard.
- Progress will be monitored by the Education and Training Leads and professional leads and reported to the Education Governance Group in January 2019.

Integrated clinical audit of risk and care plan (March 2018)

The findings included some levels of non-compliance with specified standards – 'key risk areas'. The report identifies actions for mitigating risk and improving quality of practice. These actions for different CDSs include:

- Identifying training needs – in care planning and recording – within the broader context of improving the electronic recording system and the recording infrastructure.
- Review of minimum clinical standards and offer training to teams; all new staff to receive care plan and recording training.
- Deliver training on care planning and crisis and contingency planning in line with the standards (also to be delivered to carers), along with use of supervision (link supervision agendas to the standards); use of QI projects and examples of good risk assessments and plans which meet all standards shared with teams (use of 'what good looks like' model for learning).
- Moving in 2018 from increasing quantity to improving quality; training to focus on involving carers and on sharing risk plans with service users and carers; audit results to inform the content of training; inviting services with good compliance to speak about safety to teams; cascading results of the audit down to the service.

Organisational Development Practitioners (ODP) service

The Head of OD reported in June 2017 and December 2018 on the ODP programme and progress in implementing it:

She noted that:

- The project aimed to promote the use of internal expertise within their system to create conditions for continuous QI in patient care. This avoids having to use expensive external experts whose impact diminishes when their projects finish and promotes sustainability.
- Throughout the course of the 12-day programme, approximately 400 development days for individuals will have been provided across East Sussex Better Together (ESBT)[12] and the Trust, although it is not clear how many Trust staff participated.
- By December 2018 there were 42 ODPs across the Trust and ESBT.
- They have a particular focus on supporting the delivery of the Trust's Workforce, QI and Clinical Strategies.
- The ODP service has been invited to assist in a variety of OD interventions from team development days to large scale stakeholder events including the Patient Safety Collaborative at KSS AHSN (January 2019), and they are working on leadership development in 13 cohorts.

A new activity log (March 2019) lists 25 Trust participants. The log lists a wide range of activities that the ODPs will be involved in, of which there are six devoted to the Thematic Homicide Review all of which were delivered to East Sussex CDS[13]. The other events included, amongst other things:

- Team away days/team building.
- Leadership development.
- Coaching and mentoring.
- 360º feedback.
- MBTI.
- Strategy workshops.

The Trust provides a comprehensive five-day Preventing and Managing Violence and Aggression (PMVA) programme with clearly set out and detailed learning activities and learning outcomes for the theory sessions; and a timetable for the five days. A report to the Safety Committee in January 2019 set out the principles behind RRI, data on the incidents of restrictive interventions (RIs)[14] across the Trust and in different wards. Actions taken by the Trust at this time included revisions to the PMVA course, reflecting current best practice and guidance.

The Trust has an RRI Action Plan, reviewed in June 2019. In relation to training and education, the plan notes that RRI is now included in Preceptorship and Band 6 development courses. Bespoke physical interventions training is provided to staff working in domiciliary care, in addition to the positive behavioural support training

[12] The East Sussex Better Together (East Sussex County Council, East Sussex Healthcare NHS Trust, Sussex Partnership NHS Found Trust, Sussex Community NHS Foundation Trust, Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG and High Weald Lewes Havens CCG) programme aims to have a fully integrated health and social care system in East Sussex, which will ensure every patient or service user enjoys proactive, joined up care, that supports them to live as independently as possible and achieve the best possible outcomes.
[13] The Trust informed us that the content of team development days is locally driven so the centre would not impose a focus on the Thematic Homicide Review on the other CDSs.
[14] These interventions include the use of physical restraint, seclusion, long-term segregation, rapid tranquilisation and wider practices to restrict a person's liberty.

they are expected to complete. Further development of the PMVA training to meet the requirements of national standards are planned. Learning events about RRI and safety have been held in the year and more are planned. A number of performance measures are in place and monitored either centrally or by teams locally. This includes compliance with training which is monitored monthly and reported quarterly.

Clinical risk face-to-face bespoke training for teams has included North West Sussex, Early Intervention (across the Trust) and CAMHS (across the Trust). Staff report increased confidence in improving patient safety and collaborative care. The training uses national and local statistics and facilitates continuing professional development for staff, and improving practice, enhancing skills and providing a space for reflection. Training is tailored to the local area to provide local context; where attendance is difficult for staff (satellite areas) the relevant Lead Clinician has provided local team-based training.

Holistic 'risk and safety' training events have been developed (restrictive interventions, safeguarding, clinical and environmental risk, sexual safety and professional boundaries) and provided to inpatient services; further events will be planned in response to the evaluations. A similar combined package will be provided to Community team with a focus on specifically community service issues, such as missed appointments, lone working, safeguarding (children and adult).

The Clinical Lead for risk training is providing a bespoke, mandatory clinical risk and safety management training for preceptees which ensure that all newly qualified nurses and nurses new to the Trust have received this training within their first six months.

The Lead Clinician for risk training is also co-facilitating patient safety learning events, focussing on specific SIs – for example around collaborative risk assessment. This training package links with the Trust's suicide prevention strategy, 'towards zero suicide' and the ToC. Plans for the training programme include increased co-production with experts by experience, carer leads and peer support workers. Care planning, and crisis and contingency training packages are being delivered across all services, including inpatient, specialist services, crisis teams and community teams.

For the Patient Safety Events – Learning and Improvement, the evaluation form includes the following questions:

The evaluation form includes the following questions:

How relevant was this training to your job?

How confident are you that this training will help to improve patient safety?

Quality of training sessions which the learner can assess as 'excellent' 'good' ''average' 'poor'.

Would you recommend this training to a colleague?

The following table contains a summary of evaluation sheets provided for the patient safety events 'learning and improvement'

Topic	Relevance	Confident or very confident	Training quality – rated excellent or good	Recommend to a colleague
Safeguarding children and adults	All	31/34	Great majority	Not recorded
Risk assessment and involving carers (April 2019)	All	All	All	All
Risk assessment and involving carers (July 2018)	All	All	Majority	All
Evaluation of risk assessment and involving carers (June 2018)	All	18/19	Great majority	All
Local serious incidents (Sept 2018)	All	All	All	All
Safeguarding (Nov 2018)	All	24/27	Great majority	All
Safeguarding (Sept 2018)	All	All	All	All

The evaluation forms also provide space for written comments – these again are generally very positive.

'Learning from Serious Incidents' Conference September 2018. The morning included sessions on 'keeping the person central'; involving the family in care; a carer's story; the Trust's learning from SIs and from CQC inspections. In the afternoon, sessions covered compassionate care, reflections and support for staff/teams following a serious incident; questions; information about Trust role in inquests; and about creating a 'just culture'. Some 240 people from across the Trust attended, ranging from HCAs and student nurses to consultant psychiatrists and senior managers. Nursing (inpatient and community) was most heavily represented, with other professions including occupational therapy, social work and psychology.

Appendix I Carer involvement and Triangle of Care

This appendix contains additional detail from the information submitted by the Trust to provide evidence of its implementation of Recommendation 8.

Action a) Recruit Carers Lead to support and drive through improvements for carers (including Triangle of Care).

- Five videos on the Trust's Triangle of Care (ToC) website page[15], including the three noted previously; the CEO promoting carers rights and one promoting the Carers Rights Day in November 2018.
- The Trust received a 'Carer Friendly Communities Award' from Care for the Carers (the East Sussex carer support voluntary organisation). This is reported in the Careline magazine (Winter/Spring 2018). The award recognises the work of the Trust in listening to carers, learning more about their needs and adapting their services to be more carer friendly.
- The Trust website (created in August 2017) includes pages devoted to carer support and specifically about the ToC. The general information for carers includes:
    - A link to the Improving Carers Experience project website, and reference to their information booklet for carers
    - Your health and wellbeing
    - How to get help in a crisis
    - How to get a carer's assessment
    - Relating to the person cared for
    - Benefits for carers
    - A carers' charter – the values, principles and standards which guide the Trust in providing support for carers (developed in conjunction with carers).
- The ToC page of the website includes sections headed:
    - Who is a carer?
    - What is ToC?
    - What does ToC mean for our service users? (including video)
    - What does ToC mean for family and friend carers? (including video)
    - What does ToC mean for our staff? (including video)
    - What does ToC mean for Sussex Partnership (including videos)?
    - The story so far.
    - The Trust's strategic partners (the three carer support groups in Sussex, which are Carers Support (West Sussex); Care for the Carers (East Sussex) and Carers Centre (Brighton and Hove)
    - Useful resources and contacts.

[15] Sussex Partnership Triangle of Care

- The 'Care for the Carers' (East Sussex) magazine (Winter/Spring 2018) includes a report from the Trust-wide Carers Leader and a staff member who facilitated a workshop for carers on good practice in sharing mental health information with carers.
- Improving Carers Experience information booklet is produced with carer involvement and includes a comprehensive range of information, educational courses for carers in East Sussex and signposts carers to sources of additional information and support. This includes information on involving carers in monitoring and developing mental health services. The booklet was funded by the Trust in 2016 and 2018. (The information is also available at: Improving Carers Experience.)
- A Twitter account and an email account for families have been set up – links were provided to us.
- The Trust has held events which promote ToC, including an agenda item at a conference for community nurses on learning from serious incidents.
- Local ToC meetings have been held in Eastbourne for community and inpatient staff, for carers and the carer support organisation; and by the forensic service for community and inpatient staff, and for carers.
- 'ToC One Year on' was published on the Trust website in October 2018. Coming soon are 'bite-sized videos' on how to record information about carers and the importance of doing so.
- A selection of tweets promoting ToC 'One Year on' and carers' rights day (November 2018).
- Peer review of self-assessments with Kent and Medway NHS and Social Care Partnership Trust.
- The agenda for a Trust induction day for new staff included an item on 'views from a service user and carer'. There was also a 'Market Stall' about ToC and carer resources.

Action b) Review progress with Triangle of Care and other relevant programmes that promote effective carer involvement and improve experiences.

Particularly pertinent examples from the ToC Advisory Group minutes include:

- Details of an audit of carer information in Carenotes.
- Description of a presentation by the Carenotes team regarding the carer information tab on the electronic record – this provides a clear location for recording information, which can capture if a carer assessment has been offered or if carer has other caring responsibilities. In January 2019 a training video was produced for staff about the Carers tab on Carenotes, and the importance of recording carer information. (Carenotes has been developed so that the Trust can monitor compliance with the ToC standards.)
- Report of 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.
- The ESBT Alliance has established a 'carers social prescription' to assist healthcare professionals to identify carers and signpost them to relevant services.

- Reported that a Carers' pack had been developed for use in the West Sussex CDS in September 2018, which had been well received by carers. This pack contained:
    - a welcome letter
    - a leaflet on carers support
    - information about the carers support learning and wellbeing programme
    - the Improving Carers Experience booklet, and
    - a guide for support and confidentiality for family and friend carers.
- Reported that the Bognor and Chichester ATSs had been holding carer surgeries (September 2018).
- Presentation by West Sussex Young Carers (September 2018).
- Reported that there has been a 'shift forward with regard to carers' (September 2018).
- Brighton and Hove CDS reported that there will be 2 full-time carer assessment workers at Mill View Hospital. They are seconded into the Trust and will cover both inpatient and community services, with a focus on 'reviews and carer assessments' (September 2018).
- In September 2018, it was reported that 85% of inpatient and associated services had completed ToC self-assessment.
- The minutes of the December 2018 meeting recorded that the CQC attended to observe. Topics for discussion included:
    - An IT team video which was viewed and circulated for feedback.
    - Trust-wide Carers Leader reported the teams should be having regular self-reviews of assessments and action plans to keep them live.
    - Feedback from the Carers Rights Day in November 2018.
- Trust-wide Carers Leader explained the purpose for the ToC Advisory Group – and rationale for introduction of the ToC. (June 2018).
- Report on activities planned by various teams and services for the 2019 carers week (March 2019).
- 94% of inpatient and related teams have completed their self-assessments (March 2019).

Action 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.

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.

The Trust provided the following evidence that they had implemented this recommendation:

- Duty of Candour policy and policy on a page; Duty of Candour leaflet;
- Description of the role and leaflet for carers about the Family Liaison Leads

- Family Liaison Leads training leaflet for all who have completed a two-day Root Cause Analysis course. Attendance also recommended for any managers/clinical leads expected to engage with families following an SI.
- Minutes of Safety Committee and Safety Committee exception report to the Quality Committee demonstrate that a carer and service user are members of the Safety Committee.
- SI Assurance report to Executive Management Committee meeting – includes compliance with Duty of Candour and reasons if not compliant.

'Learning from Deaths'[16] – guidance on how to involve and support families was published in July 2018 and is incorporated into the Serious Incident process. The guidance sets out principles including:

- Bereaved families and carers should be treated as equal partners following a bereavement.
- Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment.
- Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support.
- Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one.
- Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed.
- Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.
- Bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations.

Action g) Carers rights day, a suite of activities planned for 25 November 2017.

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

These included:

- Carers rights day (October 2016)
- Carers Week 2017 – summary of Carers Appreciation Day
- Carers rights day (November 2017)
- Promotion of 'Celebrating Carers week' (June 2018)
- Promotion of Carers Rights Day (November 2018) – poster and web page – listing events

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

- Young carers awareness day (January 2019)
- Plans for 2019 carers week activities recorded.

Appendix J Supplementary information relating to the Clinical Commissioning Group

NHS England Serious Incident Framework – supporting learning to prevent recurrence – information about action plans

NHS England recommends use of the NPSA Action Plan template which is available online at NPSA root cause analysis guidance.

The minimum requirements for an action plan include the following:

- Action plans must be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions (not an investigator who has nothing to do with the service although clearly their recommendations must inform the action plan).
- Every recommendation must have a clearly articulated action that follows logically from the findings of the investigation.
- Actions should be designed and targeted to significantly reduce the risk of recurrence of the incident. It must target the weaknesses in the system (i.e. the 'root causes'/most significant influencing factors) which resulted in the lapses/acts/omissions in care and treatment identified as causing or contributing towards the incident.
- A responsible person (job title only) must be identified for implementation of each action point.
- There are clear deadlines for completion of actions.
- There must be a description of the form of evidence that will be available to confirm completion and to demonstrate the impact implementation has had on reducing the risk of recurrence.

A SMART approach to action planning is essential. That is, the actions should be 'Specific, Measurable, Attainable, Relevant and Time-bound'. To ensure that the most effective actions/solutions are taken forward, it is recommended that an option appraisal of the potential actions/solutions is undertaken before the final action plan is developed and agreed.

Submission of Final Report, Quality Assurance and Closure

Submission of Final Report

Serious incident reports and action plans must be submitted to the relevant commissioner within 60 working days of the incident being reported to the relevant commissioner, unless an independent investigation is required, in which case the deadline is six months from the date the investigation commenced. In certain circumstances, Trusts may find it difficult to complete a final report within these timescales. This might be due to:

- enforced compliance with the timetable of an external agency, such as police, Coroner, Health and Safety Executive or Local Children Safeguarding Board or Safeguarding Adult Board

- investigation of highly specialised and multi-organisation incidents, such as those involving a national screening programme, or
- incidents of significant complexity.

In such circumstances the commissioner and investigations team can agree an alternative timeframe. This should be clearly recorded within the serious incident management system and included in the serious incident report.

Quality Assurance and Closure of the Investigation

On receipt of the final investigation report and action plan from the provider, the commissioner should acknowledge receipt by email. They will then undertake a quality assurance review of the report within 20 calendar days. Where necessary an alternative timescale may be agreed.

It may be necessary to involve several commissioning organisations in the quality assurance and sign-off process depending on the nature and circumstance of the incident. The relevant Director (or equivalent) within the commissioning organisation responsible for managing oversight of the serious incident must ensure a robust and transparent process is in place for assurance and closure of serious incidents. This must preclude the involvement of members of the investigation team. There may be occasions where commissioners wish to make arrangements for another internal team or a separate commissioning organisation to undertake an additional quality assurance review where there is a risk of conflict of interest. This does not remove their overall responsibility to ensure that the report, action plan and implementation of necessary actions meet the required standard. The serious incident report, closure process and meeting minutes must clearly describe the roles and responsibilities of those involved in the reporting, investigation, oversight and closure of the serious incident to demonstrate good governance and provide a clear audit trail.

The commissioner must seek assurance that the report fulfils the required standard for a robust investigation and action plan.

Any concerns or areas requiring further action should be highlighted to the provider at the earliest opportunity to facilitate timely action and resolution of issues raised. It may be acceptable to close the incident before all preventative actions have been implemented and reviewed for efficacy. For example, where actions are continuous or long term, the commissioner may consider closure once there is evidence that such actions have been initiated. Where this is considered acceptable, robust arrangements should be put in place to ensure implementation is regularly reviewed. Cases can be re-opened where there is a requirement to do so i.e. upon receipt of new information derived from any of the mechanisms previously outlined in Part One, section 1.3 of the guidance.

Publication of serious incident investigation reports and action plans is considered best practice. To support openness and transparency, local commissioners should work with their providers to encourage and support publication of reports and action plans. Where reports are published, there must be robust processes in place for proofreading and steps must be taken to protect the anonymity of persons involved. Reports should not contain confidential personal information unless consent has been obtained or there is an overriding public interest (as described in section 4.4).

The content must be considered by the organisation's Risk Manager (or relevant officer) with support from the organisation's Caldicott Guardian and legal advisor/team as required. It is important to share information safely for the purposes of learning whilst maintaining the principle of openness and transparency.

Closure

It is important to recognise that the closure of an incident marks only the completion of the investigation process. The delivery and implementation of action and improvement may be in its infancy at this stage. Implementing change and improvement can take time, particularly where this relates to behavioural and cultural change. It is not unreasonable for improvements to take many months or even years in some cases.

It is important that providers and commissioners invest time and resources into monitoring and progressing long term actions, particularly where these address the causes contributing to other incidents across the system. A mechanism for the monitoring and review of actions should be agreed by the provider and commissioner.

Patients and families involved may also wish to maintain their involvement with the organisations after the investigation is closed to seek assurance that action is being taken and that lessons really are being learned. Opportunities for future involvement should be made available where this is the case.

In order to prevent issues from being considered in isolation and common trends from being missed, investigation reports and action plans should be reviewed collectively by providers on a regular basis. A more collective approach can help to make the delivery of multiple action plans more manageable and can also help inform wider strategic aims for the organisations involved.

Closure checklist:

Set up/preparation

- Is the Lead Investigator appropriately trained?
- Was there a pre-incident risk assessment?
- Did the core investigation team consist of more than one person?
- Were national, standard NHS investigation guidance and processes used?

Gathering and mapping

- Was the appropriate evidence (patients notes/records, written account) used (where it was available)?
- Were interviews conducted?
- Is there evidence that those with an interest were involved (making use of briefings, de-briefings, draft reports etc.)?
- Is there evidence that those affected (including patients/staff/victims/perpetrators and their families) were involved and supported appropriately?
- Is a timeline of events produced?

- Are good practice guidance and protocols referenced to determine what should have happened?
- Are care and service delivery problems identified? (This includes what happened that should not have, and what did not happen that should have. There should be a mix of care (human error) and service (organisational) delivery problems).
- Is it clear that the individuals have not been unfairly blamed? (Disciplinary action is only appropriate for acts of wilful harm or wilful neglect).

Analysing information

- Is there evidence that the contributory factors for each problem have been explored?
- Is there evidence that the most fundamental issues/or root causes have been considered?

Generating solutions

- Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed?
- Are actions assigned appropriately? Are the appropriate members i.e. those with budgetary responsibility involved in action plan development? Has an options appraisal been undertaken before final recommendation made?

Throughout

- Is there evidence that those affected have been appropriately involved and supported?

Next steps

- Is there a clear plan to support implementation of change and improvement and method for monitoring?

'Policy and Procedures for Reporting and Managing Incidents and Serious Incidents' v9 October 2018

This document sets out the processes and procedures for the reporting and management of incidents and Serious Incidents (including near misses), both clinical and non-clinical, in relation to the CCG and the services it commissions.

Amends previous policy by aligning policy across all STP CCGs.

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

This policy details how to report all incidents and near misses whether clinical or non-clinical, including serious incidents and notifiable incidents. It applies to incidents that involve commissioned services, as well as for the CCG, i.e. for patients, carers,

visitors, staff, premises, property, other assets, data, or any other aspect of the organisation.

All serious incidents are logged on a national database system called STEIS (Strategic Executive Information System). CCGs have designated responsibility for approving closure of serious incidents for commissioned service providers. Serious incidents occurring in Sussex are managed by the Sustainability and Transformation Partnership (STP) Patient Safety Team, which provides this service on behalf of all Sussex and East Surrey CCGs.

The CCG and all service providers providing NHS care are expected to comply with the NHS England Serious Incident Framework (2015).

Serious Incidents

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

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, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. 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.

There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. However, examples of possible serious incidents are illustrated in Appendix 3.

Serious Incident (SI) reporting

STAGE 1 – Initial reporting within the CCG.

- When it is suspected that an incident may fulfil the criteria of an SI the STP Patient Safety Team should be contacted and given a summary of the incident. The incident should also be reported to the appropriate CCG senior manager and the Corporate and Communications team, if there is potential for significant media interest. The Communications team will inform the Area Team Communications department and CCG Executive Team as required.
- Out of hours, Serious Incidents should be reported to the CCG on-call Director who will liaise with the NHS England on-call Director as appropriate.

STAGE 2 – Reporting onto the national STEIS database. If a CCG incident is agreed to be a serious incident, the incident will be recorded and entered onto STEIS by the

STP Patient Safety Team, completing as much of the detail as is possible at the time of entry.

- All SIs should be entered onto STEIS no later than two working days after the organisation becomes aware of the incident.
- SIs occurring in Primary Care will be logged on STEIS by NHS England.

STAGE 3 – Investigating an incident or serious incident.

Investigation of incidents and serious incidents, attributed either to the CCG, commissioned services or independent providers of NHS care, are carried out in accordance with the NPSA and NHS England framework for managing serious incidents. The usual method of investigation is a Root Cause Analysis.

Where a serious incident is also subject to investigation via the Safeguarding process (for children and adults at risk), the CCG will work together with the Local Authority and Area Team to ensure a thorough investigation is concluded that meets the requirements for both Safeguarding and SI investigation processes.

The STP Patient Safety Team will monitor that investigations of serious incidents are completed and submitted to the CCG within agreed timescales, i.e. 60 working days from the date submitted on STEIS.

STAGE 4 – closure of incidents and serious incidents.

- All SIs reported submitted to the STP Patient Safety Team will be reviewed initially by the Patient Safety Manager prior to submitting to the Sussex and East Surrey Serious Incident Scrutiny Group, which meets on a fortnightly basis (see Appendix 4 for Terms of Reference of the group).
- In line with the NHSE Serious Incident Framework (2015) the Serious Incident Scrutiny Group approves closure or otherwise of all serious incidents commissioned by CCGs. At present (October 2018), but subject to change SIs in services specially commissioned by NHS England (e.g. secure and forensic mental health) will be forwarded to NHS England for scrutiny and closure.
- Formal written feedback from the scrutiny panel (including requests for further information to enable closure) is given via the STP Patient Safety Team to the service provider's patient safety and/or governance leads.
- SIs given conditional closure status by the SI scrutiny group can be closed by the respective CCG Heads of Quality (or delegated Quality Lead) following a satisfactory response to the SI Scrutiny Panel feedback. SIs given a 'kept open' status are submitted back to the SI Scrutiny Panel for further scrutiny following receipt of additional information.
- Extensions to submission deadlines of investigations reports may be granted for any delay in the investigation which is outside of the organisation’s control. Examples include:
  - Police investigation.
  - Safeguarding investigation.
  - Awaiting statements or reports from individuals not employed by the Provider organisation.
  - Awaiting external investigation reports
  - Extensive investigation required.

- Complexities around implementing the Being Open policy.

Terms of Reference for the Sussex and East Surrey SI Scrutiny Group

Overall purpose:

To review SI investigation reports for NHS providers (to include independent organisations providing NHS-funded care commissioned by CCGs) across Sussex and East Surrey CCGs as reported on STEIS (Strategic Executive Information System). The group enables individual CCGs to discharge their responsibility for closure of serious incidents as described in the NHS England Serious Incident Framework (updated March 2015).

Aims and Objectives:

This process will be managed by the STP Patient Safety Team, which is hosted by Brighton and Hove Clinical Commissioning Group, as clarified in a signed Service Level Agreement, on behalf of the following CCGs:

- Brighton and Hove.
- Coastal West Sussex.
- Crawley.
- High Weald Lewes Havens.
- Horsham and Mid-Sussex.
- Eastbourne, Hailsham and Seaford.
- Hastings and Rother
- East Surrey.

Membership:

A core group of representative members are required which includes the following:

- STP Quality Senior Leadership team.
- Quality Managers across the STP team.
- Patient Safety Team Manager (hosted service).
- Patient Safety Team Officer (hosted service) or nominated administrator.

Following alignment of quality teams and functions across the STP, there is agreement that attendance from representatives of every CCG is not required for panel meetings. This arrangement marks a change to the previous terms of reference. However, there is a recognition that 'coordinating CCG' responsibilities remain with named STP Quality Leads. Therefore, there is still a requirement for Quality Leads of their respective providers to provide a view on closure (or otherwise) for individual SI reports where they (or a nominated deputy) are not in attendance at a panel meeting.

Providers are invited to attend scrutiny group meetings, by exception, where it has been identified as beneficial for the panel. This may include particularly complex cases where specialist knowledge from the provider can support panel decisions. The STP Quality Senior Leadership Team/Panel Chair will be responsible for

requesting provider attendance with support from the Patient Safety Manager following first-line triage, which may indicate provider attendance.

Quoracy:

For the scrutiny panel to remain quorate there will be a requirement for a minimum of two members of the STP Quality Senior Leadership Team, one of whom will be the Chair. A minimum of four members from the STP-wide quality team is required for a panel meeting.

Members will need to have a sufficient level of seniority in the clinical commissioning groups and have enough knowledge (or represent the views of other relevant clinicians outside the group) to aid effective decision making.

Frequency of meetings:

There may be occasions when an extraordinary meeting may be convened e.g. for a higher profile incident, a homicide review, or when a high volume of serious incident reports have exceeded their submission date and require closure.

Submission and Standard Documentation

All SI reports and action plans submitted to the Patient Safety Team will be submitted:

1) With a Standard SI closure Submission Form front sheet attached.
2) On an approved template following the NPSA format.
3) Fully anonymised*.
4) With any requested amendments (following 1st line triage or panel review) in a different coloured font or highlighted.

* Providers are advised to be able to offer an identifiable copy for patients and families on request.

Closure criteria

Submitted SI reports received by the Patient Safety Team will be quality assured ("1st line triage") by the Patient Safety Manager. This provides an opportunity for clarification or questions to assist the panel in decision making and improve the likelihood of closure of a report on first panel review.

An SI will be closed when evidence of the following has been submitted:

- A comprehensive, objective, analytical report of the incident.
- Duty of Candour legislation followed and clearly demonstrated.
- Clear and robust investigation process and RCA methodology followed.
- Service/care delivery issues accurately identified and root cause. identification (or clear rationale if no root cause is identified).
- The learning identified for each root cause and significant service/care delivery issue.
- A SMART action plan that covers all identified learning including responsible individuals (by role) and timescales.

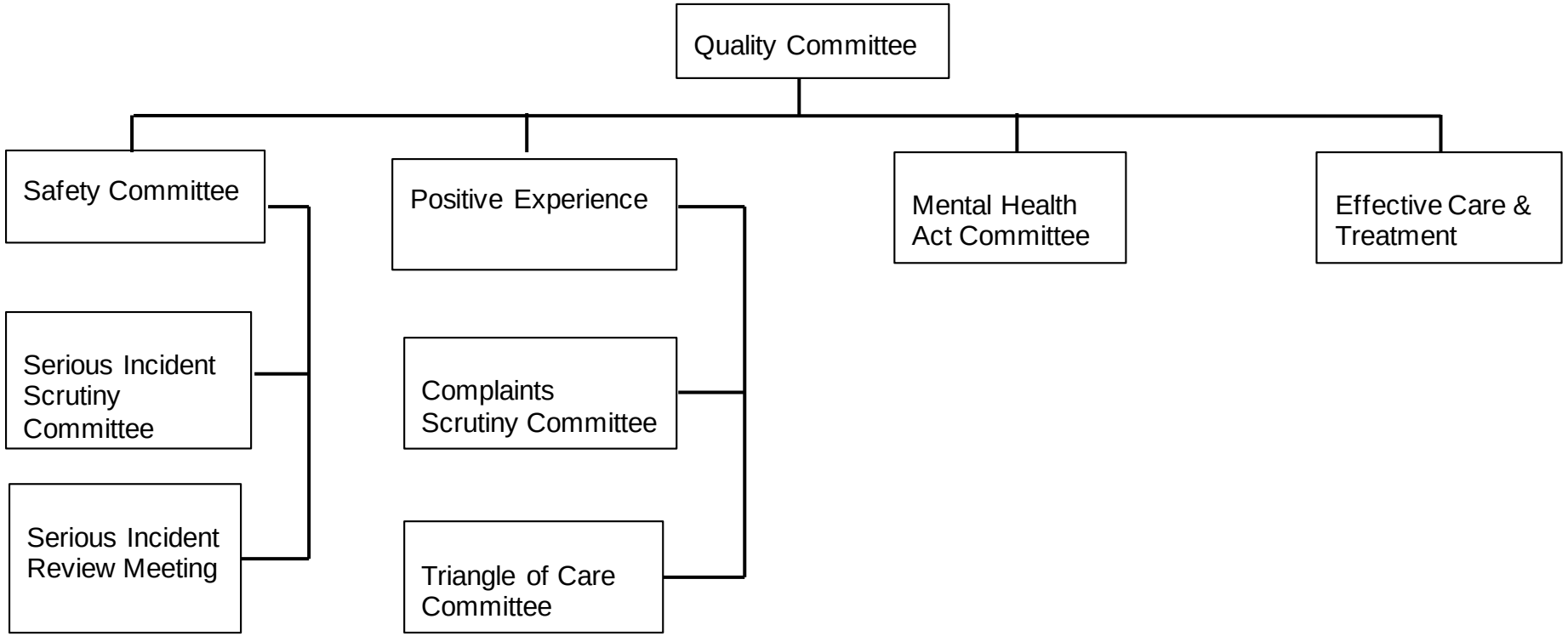
- Evidence that the final report has been scrutinised via the provider governance process and authorised at an appropriate senior level.
- The final report should be submitted in a format that can be wholly understood by patients, families and carers alike. All medical terminology and abbreviations should be fully explained either in the sub text (footer) or in a glossary. An easy read version should be made available for any patients with a learning disability, Braille version for any patients who are registered blind and evidence that an interpreter has been considered if a language barrier is identified.

An SI may be approved for closure without all the above criteria being met. Where the panel advises changes should be made to a report (for instance, re-wording that would benefit a family or suggested re-phrasing of a root cause), this is captured as feedback for the provider in the panel minutes.

Following SI closure via the scrutiny panel, it is the responsibility of the coordinating CCG to gain assurance that action plans have been implemented via contracted quality review meetings with their respective provider.

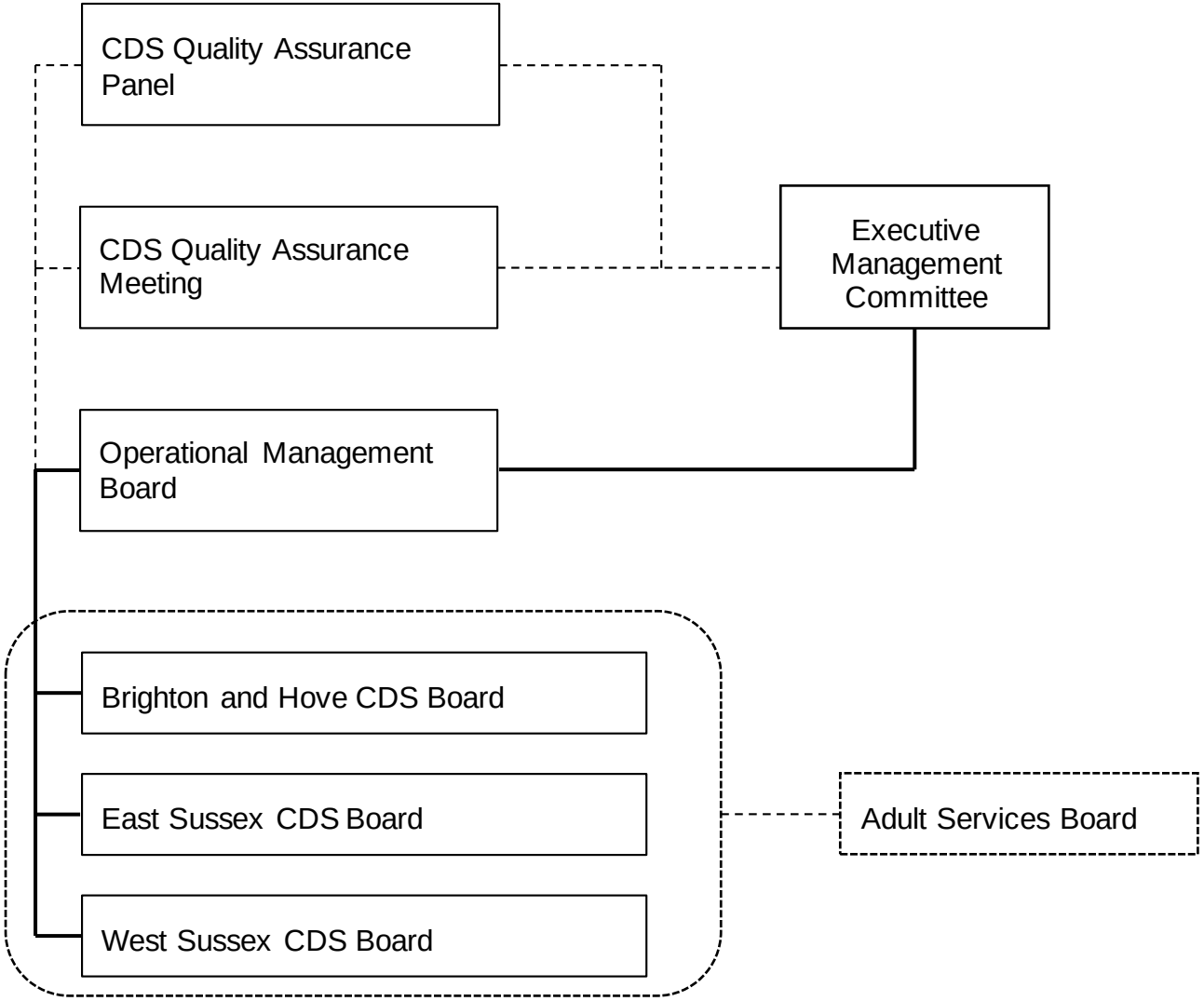
Appendix K Trust's Committee structure (simplified)

The Quality Committee reports directly to the Board of Directors



Operational Committees

The Executive Management Committee reports directly to the Board of Directors



Appendix L Membership of Committees

Governance related committees

Board of Directors	Quality Committee	Safety Committee	Serious Incident Scrutiny Committee	Serious Incident Review meeting
Chair	Non-exec Director (chair)	Deputy Chief Nurse (co-chair)	Chief Executive (chair)	Chief Nurse (co-chair)
Chief Executive	Non-exec Director (vacant)	Assoc Medical Director (co-chair)	Chief Nurse	Chief Medical Officer (co-chair)
	Chief Medical Officer		Deputy Chief Nurse	Head of Incident Management and Safety
Chief Nurse	Chief Nurse	Assoc Director of Nursing Standards and Safety	Chief Medical Officer	
Chief Operating Officer	Chief Operating Officer	Deputy Chief Nurse (Safeguarding)	Chief Operating Officer	
Chief Finance Officer	Clinical Director – Clinical Strategy	Assoc Director of Nursing	Serious Incident Co-ordinator	
Director of HR and OD	Joint Director of Psychology and Psychological Therapies	Head of Incident Management and Safety	Attended by Serious Incident report lead investigator	
Chief Digital and Information Officer	Deputy Chief Nurse	Representative of ChYPS CDS		
Director of Corporate Affairs	Director of Corporate Affairs	CAMHS EIP		
Director of Communications	Director of Innovation and Improvement	Assoc Director of Nursing Physical Healthcare		

Director of Clinical Strategy	Director of HR and OD	Coastal CCG		
Chief Medical Officer	Lead Consultant Psychiatrist, Coastal NW Sussex	CAMHS Clinical Psychologist		
	Deputy Chief Nurse, Safeguarding and Physical health	Lead Consultant Psychologist, representing Acute Crisis Service		
	Acting Assoc Director of People Participation	Service Director Coastal and North West Sussex, representing W Sussex CDS		
	Director of Estates and Facilities	Estates and Facilities officer		
	Assoc Director of Nursing	Nurse Consultant		
	Assoc Director of Nursing Standards and Safety	Director for Learning Disabilities Quality and Safety Assurance Manager		
	Assoc Director of Quality Improvement	General Manager, Health in Mind		
	Council of Governors Representative, Carer (observing)	Quality Improvement Lead		
	Council of Governors Representative, (observing)	CCG representative		
	Council of Governors Representative, (observing)	Deputy Director Capital Projects, Assurance and Environmental Services		

	Service Director, PCandW Services			

Operational related boards, committees, panels and meetings

Board of Directors	**Executive Management Committee**	**Operational Management Board**	**CDS Quality Assurance Panel (CHYPS)**	**CDS Quality Assurance Meeting**
Chair	Chief Executive (ch)	Chief Operating Officer (ch)	Chief Operating Officer (ch)	Chief Operating Officer/ Chief Executive
Chief Executive	Chief Finance Officer	Transformation Director	Assistant Executive Director	Performance Director/ Chief Nurse
Chief Nurse	Chief Operating Officer	Performance Director	Contracts Deputy Director	Finance Department representative
Chief Operating Officer	Director of Corporate Affairs	Director of Innovation and Improvement	Financial Controller	HR Department representative
Chief Finance Officer	Director of Communications	Clinical Director – W Sussex CDS	Performance Director	
Director of HR and OD	Director of HR and OD	Senior Financial Controller	Senior Financial Controller	
Chief Digital and Information Officer	Chief Digital and Information Officer	Financial Controller COR FP Operations Financial management	Personnel Manager (HR)	
Director of Corporate Affairs	Director of Clinical Strategy	Head of Strategic Estates Planning	Chief Nurse	
Director of Communications	Operational Director – Forensic Healthcare	Operational Director – Forensic Healthcare	Chief Financial Officer	
Director of Clinical Strategy	Operational Director – Children and Young People's and Learning Disabilities	Operational Director – Children and Young People's and Learning Disabilities	Chief Medical Officer	
Chief Medical Officer	Director for LD and Neurobehavioural Services	Registered Clinical Services Director	Director of HR and OD	

	Service Manager – Health in Mind	Operational Director – Adult Services	Operational Manager CAMHS and Learning Disabilities Services	
	Chief Nurse	Deputy Chief Nurse	General Manager CAMHS/ChYPS	
	Clinical Director for PCW ES Health in Mind	Associate Director for Education and Training	Nurse Consultant	
	Clinical Director Mill View Hospital	Quality and Safety Assurance Manager		
		Clinical Director – ChYPS		
		Service Director – Primary Care and Wellbeing		
		Director of HR and OD		
		Director of Corporate Affairs		
		Chief Digital and Information Officer		
		Chief Medical Officer		
		Service Director – Learning Disabilities		
		Clinical Director – Forensic Healthcare		
		Head of Charity		
		Clinical Director – Primary Care and Wellbeing		
		Head of HR Operations		
		Head of Employee Relations and Business Partnering		

		Clinical Director – E Sussex CDS		

Appendix M Quality Improvement

The following provides a brief overview of what Quality Improvement (QI) is about. Our source text is Naylor and Ross[17]:

> "Quality improvement is a systematic approach to improving health services based on iterative change, continuous testing and measurement, and empowerment of frontline teams." (p. 1)

Key features include:

- strong emphasis on co-production and service user involvement
  - leaders play a key role
  - board level commitment
- engage directly and regularly with staff and empower front-line teams to develop solutions rather than imposing them from the top
- those directly involved in giving and receiving a service are best placed to improve it' (pp. 3-4).

In order to 'maximise success' QI projects need several enabling conditions, including:

- ongoing organisational commitment
- devolution of decision-making responsibilities to frontline staff
- evaluation and sharing learning across the organisation (p. 16).

East London NHS Foundation Trust was cited as a case study, noting the Trust's focus on quality – the CQC cited that commitment as a 'contributing factor to the trust's 'outstanding' rating in 2016'. The Trust developed the infrastructure necessary 'to support large-scale application of quality improvement' including (p. 17):

- a central quality improvement team
- quality improvement coaches
- quality improvement sponsors
- people participation team
- digital systems.

Improvements include (p.18):

- a 42 % reduction in physical violence incidents across all East London wards leading to a 'major positive effect on service user and staff experience, higher levels of staff satisfaction, improved retention rates and lower sickness absence'
- a reduction in the number of incidents on six older peoples' wards by 36%, leading to a 49 per cent reduction in associated costs
- a 25% reduction in time from referral to assessment across 15 community teams and a 33% reduction in first appointment non-attendances while seeing a 25% increase in referral volume.

---

17 Naylor, S, and Ross, C. (2017) Quality Improvement in Mental Health. The King's Fund

‘The 2016 NHS Staff Survey showed that ELFT had the highest staff engagement score for a combined mental health and community trust in the country, and the highest score across all providers for staff feeling able to make improvements in their workplace’ (p.18).