

**Assurance Review commissioned by NHS England South  
Regional Office**

**Evidence of actions by Sussex Partnership NHS Foundation  
Trust following independent investigation SN StEIS  
2012.20537**

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Niche Patient Safety is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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# 1 Introduction

- 1.1 NHS England South commissioned an assurance review of actions taken by Sussex Partnership NHS Foundation Trust (the Trust) following the SN (StEIS number 2012.20537) independent mental health homicide investigation, which was published in July 2015.
- 1.2 The scope of this piece of work was:
- to review evidence of action plan completion
  - to review embeddedness of lessons learned

And to identify:

- the degree and success of the implementation of the Trust action plan
- the extent of evidence for implementation and monitoring for embedded change
- governance and quality monitoring processes for serious incident reporting and management

# 2 Process

- 2.1 The Trusts' action plan following the completion of the independent investigation was accepted at the prepublication meeting on 16 July 2015. It was agreed that the action plan review would be carried out after a six month period, with input from NHS Hastings and Rother CCG and NHS Eastbourne, Hailsham and Seaford CCG.
- 2.2 The Trust supplied the completed version of the action plan, with evidence embedded.
- 2.3 A briefing about the implementation of the action plan took place with the Director of Nursing Standards and Safety, to provide background information regarding changes that have been made regarding the management of serious incidents (SIs) across the Trust.
- 2.4 A meeting to review the action plan implementation took place on 29 January 2016 at Eastbourne Assessment and Treatment Services (ATS) offices in Eastbourne, attended by:
- Lead investigator, Niche Patient Safety Ltd
  - Chief Nurse, NHS Hastings and Rother CCG and NHS Eastbourne, Hailsham and Seaford CCG
  - Head of Quality, NHS Hastings and Rother CCG and NHS Eastbourne, Hailsham and Seaford CCG
  - General Manager, Eastbourne adult services
  - Service Manager (at the time of the SI)
  - Service Manager (current)
  - Lead psychologist, Eastbourne

- Trust Interim Head of Risk and Safety

### 3 Documents reviewed

- The completed Trust action plan for StEIS number 2012.20537 completed in June 2015.
- Trust revised 'Incident & Serious Incident Reporting Policy & Procedure' dated December 2014
- Trust reviewed 'Level 2 (SI) Review Report (Root Cause Analysis)' reporting template
- Trust 'Being Open' policy dated November 2010
- Internal Psychology and Psychological Therapy Referral process and pathway, referrals database (anonymised) and an example response.
- Sussex Partnership NHS Foundation Trust 'Report & Learn Bulletin' October, November and December 2015.
- Active Engagement Incorporating 'Did not Attend' Policy and procedure.
- Minutes of Sussex Partnership NHS Foundation Trust 'Report & Learn Forum' December 2015
- Trust log of SIs tracking key milestones and updates
- East Sussex County Council Mental Health Directory of Community Support, August 2015
- Sussex Recovery College (East Sussex) Prospectus, Spring 2016

### 4 Independent investigation recommendations

4.1 Six recommendations were made in the independent investigation and this report is structured using the recommendations as headings, with updates and evidence described.

#### 4.2 Recommendation 1.

Commissioners should consider developing pathways of care that identify young people at risk of mental health problems in custody, and co-ordinates their care across primary and secondary mental healthcare, and youth justice teams

#### 4.3 Recommendation 2.

The Trust should ensure that serious incident investigations are of the requisite quality standard and are sufficiently rigorous and robust to enable proper organisational learning.

#### 4.4 Recommendation 3.

The Trust should ensure that staff undertaking serious incident investigations are suitably trained, prepared and supported.

#### 4.5 Recommendation 4.

The Trust should ensure that the clinical risk assessment and management and active engagement policies are consistently implemented.

#### **4.6 Recommendation 5.**

The final outcome of contact with secondary mental health services should always be communicated to the service users' GP. The CCG and Trust should agree the routes of communication between secondary mental health services and GPs, and embed these into practice

#### **4.7 Recommendation 6.**

Following a serious incident such as a homicide, the Trust should incorporate best practice guidance available, including contacting both victim and perpetrator's families to agree how they would like to be engaged, using the resources of Police liaison and homicide teams, victim support or other available advocacy or support services.

## **5 Review of implementation of recommendations**

### **Recommendation 1**

**Commissioners should consider developing pathways of care that identify young people at risk of mental health problems in custody, and co-ordinates their care across primary and secondary mental healthcare, and youth justice teams.**

- 5.1 There is a Trust mental health worker within the Youth Offending Service, who can pick up referrals of young people if previously known to CAMHS. If young people who are already known to CAMHS are arrested and remanded, there are several ways in which they may be picked up; Criminal Justice Liaison staff would be expected to assess anyone who had been arrested where there were police had concerns about mental health regardless of age; there is a part time CAMHS worker in the Criminal Justice Liaison Team; the care coordinator or worker would be expected to maintain contact if under CPA.
- 5.2 Protocols are place to handover if there is a transition to adult services expected. Regular review meetings are held between the Trust and Police to facilitate communication, and review of trends and themes. Reflections about the SN case were that he had the option to have contact with the Trust CAMHS psychologist based at YOT, and had refused a re-referral to CAMHS when leaving custody.

### **Recommendation 2.**

**The Trust should ensure that serious incident investigations are of the requisite quality standard and are sufficiently rigorous and robust to enable proper organisational learning.**

### **Recommendation 3.**

**The Trust should ensure that staff undertaking serious incident investigations are suitably trained, prepared and supported.**

- 5.3 The Incident & Serious Incident Reporting Policy & Procedure (SI) policy has undergone significant changes since the homicide, and was reviewed to meet the expectations of the NHS England Serious Incident framework (2013), with revised report templates established.
- 5.4 A complete review of the process has been undertaken, which has coincided with an increase in the level of scrutiny from CCGs. The major shifts described have been in the focus on the quality of investigations and reports, and in engaging families as quickly as possible. Reporting is assisted by electronic systems such as 'Ulysses' which provide automatic alerts to relevant senior staff.
- 5.5 A Sussex wide SI panel is attended by Trust representatives. The CCG representatives at the review meeting were positive about the Trust's SI processes, acknowledging that timeliness and quality of reporting in particular have both improved. A positive working relationship and good communication between the Trust and CCG was noted.
- 5.6 A quarterly report including SIs is provided to the Trust Quality Committee which are prepared by the Interim Head of Risk and Safety for the Director of Nursing Standards and Safety. Reporting targets to CCGs are monitored against the national target of two days. In December 2015 the Trust provided 39% of reports in two days. The Trust and CCG have agreed a programme of improvement for this. It appears in the Trust most SIs occur in the community where reporting is more challenging. Separation of reporting for inpatient and community is being considered, then issues can be more easily identified and addressed.
- 5.7 The allocation of SI reviewers is no longer undertaken centrally, but is managed locally, with the expectation of increasing ownership in the clinical areas.
- 5.8 A programme of training has been implemented, and for a reviewer to be allocated an investigation they must have attended the 2 day RCA training. The CCG SI lead was invited to attend the RCA training. A 'buddy' system was introduced, to offer support to new reviewers, and a central post that focusses on SIs has been established, to oversee and link to the local leads. Supervision for reviewers is provided by line managers who have also been trained and have themselves conducted SI reviews. An example was given where the SI reviewer attended an inquest and was given positive feedback by the Sussex coroner.
- 5.9 A central database is kept, and all Level 2 SIs are signed off by the Director of Nursing Standards and Safety. A 'panel review' structure is in place for complex SIs and deaths, chaired by the Service Director or equivalent. A

'homicide log' is kept to keep track of action plans, correspondence and family contacts.

5.10 Two aspects of the SI process are audited:

- SI process- timeliness of being informed – with the expectation that it is immediate
- Duty of Candour and family involvement – there is an awareness that the police sometimes keep the family communications internally, and are slower to inform the Trust. It was also acknowledged that this is a learning /skills need for staff.

5.11 All level 3 reports are reviewed at the Trust Suicide and Homicide review group, which is chaired by the Medical Director. This group focusses on the clinical and research evidence, for example NICE Guidelines.

5.12 The Trust's SI Review Group is chaired by the Executive Director of Nursing and Quality, and this reports on key themes to the Quality Assurance Committee, where Clinical Directors are held to account.

5.13 Each Clinical Service Delivery unit has a local clinical governance group, which is expected to act upon learning lessons from any SIs and ensure learning is embedded.

5.14 In East Sussex (where Eastbourne ATS is sited) there is a 'Report & Learn Forum' chaired by the Deputy Service Director. This is attended by local service Trust senior staff, but also by other stakeholders such as GPs, public health, local commissioners. This group shares learning but also works on local initiatives, such as the East Sussex Suicide Prevention plan, which includes work with local health and social partners on a suicide reduction plan for Beachy Head

5.15 If the SN case were to have occurred in the new structures, there would be a panel review chaired by The Service Director, attended by the Director of Nursing, the Clinical Director CAMHS and staff from substance abuse service and the criminal justice team.

5.16 The Trust is in the process of commissioning a thematic review of all homicides in the Trust over the last 5 years, and there are plans to set up a Mortality Review Group, as recommended in the recent Southern Health 'Mazars' report.

5.17 A monthly 'Report & Learn' bulletin is circulated by the Interim Head of Risk and Safety, and it is planned to produce thematic reports on relevant topics in the future.

**5.18 Recommendation 4**

**The Trust should ensure that the clinical risk assessment and management and active engagement policies are consistently implemented.**



- 5.19 Adherence to key policies is now arranged as a mandatory requirement for all clinical staff, and is audited through appraisal and monitored through supervision. Local service managers monitor this through supervision notes and appraisals.
- 5.20 The active engagement policy has been reviewed and changed. Where there is a DNA the policy now expects a phone call to be made on that day and repeated if not successful. Feedback is given directly to GPs. Clear steps to follow linked to risk assessment are outlined in the policy, and persistent non engagement is also addressed.
- 5.21 A project on DNAs is under way, led by one of the Service Managers. This will track numbers of DNAs, audit the adherence to policy, and benchmark against research evidence. The final report will then be reviewed by the ATS governance team.
- 5.22 With reference to the learning points in the SN case regarding hard to engage service users, there are now clear and creative approaches that help to ensure every effort is made not to 'lose' people to services.

## **Recommendation 5.**

**The final outcome of contact with secondary mental health services should always be communicated to the service users' GP. The CCG and Trust should agree the routes of communication between secondary mental health services and GPs, and embed these into practice.**

Systems for referral by GPs and feedback to GPs have changed radically since 2013. All GP referrals to the ATS are triaged, with a band 6 or 7 nurse available, with psychiatry and psychology available. There are standards for contact where an urgent assessment has been requested (four hours) and out of hours procedures.

- 5.23 Twice a week there is a minuted MDT discussion about referrals including which profession should make contact. Waiting times for a psychiatric or psychology referral are monitored at the triage stage, and the Trust monitors 'demand capacity analysis' and target times. As part of the crisis concordat work there will be the facility to refer via third sector agencies in the future.
- 5.24 GPs are always invited to CPA meetings and to take part in SI reviews, and CPNs are allocated to GP surgeries. Currently there are 6 or 7 referrals to psychology every week, and an average of 3 of these may be taken on.
- 5.25 With reference to the learning points in the SN case regarding referrals to psychology, a revised psychology referrals pathway has been implemented, supported by a clear process. All decisions should be documented with written feedback to the client and the referrer. These aspects of the pathway are audited and reported. A peer support worker has been appointed, supervised by a psychologist. They can offer support to families and can work alongside substance misuse or criminal justice workers. This worker also

offers support to anyone newly diagnosed with a personality disorder. A personality disorder pathway is under development, although it was acknowledged that services for adult ADHD remains a gap. The neuropsychiatry service in Brighton is no longer available for Eastbourne referrals.

## **Recommendation 6.**

**Following a serious incident such as a homicide, the Trust should incorporate best practice guidance available, including contacting both victim and perpetrator's families to agree how they would like to be engaged, using the resources of Police liaison and homicide teams, victim support or other available advocacy or support services.**

- 5.26 The principles of being open and the duty of candour have been incorporated and embedded in the revised policy. A log of duty of candour actions is kept and audited.
- 5.27 It was acknowledged that finding the right time to make contact and keep contact with families is difficult at times. Police and criminal justice processes need to be considered and worked through in accordance with the Memorandum of Understanding. If a family has been bereaved there is need to allow time for this while maintaining contact. It remains a challenge to include families in SI investigations but work is ongoing.
- 5.28 While all SI reviewers are now all RCA trained, the skills of approaching and supporting families as part of an investigation are highly specialised. The Trust has found that staff can feel deskilled in these aspects and require much support and guidance.
- 5.29 The Trust would welcome any guidance or training from NHS England on preparing and supporting staff to involve families.

## **6 Summary**

- 6.1 The Trust has evidenced that they have made significant process changes following this independent homicide investigation and these have been tracked through a variety of policy and service changes. There is evidence that there has been systems learning, through training, policy implementation and some auditing of practice.
- 6.2 We have not reviewed any commissioner response to Recommendation 1, which was intended for commissioner consideration.
- 6.3 We suggest however that a greater depth of assurance could be provided by measurement of the outcome of the changes, for example:
- use of a quality checklist for measuring the quality of investigations

- a sample of SI reports regularly audited against best practice
- feedback from GPs about their views on communication from secondary mental health services
- auditing of final contact with secondary mental health services and GP feedback
- PALS or family feedback about involvement in investigations

6.4 The transforming of the SI process is particularly noteworthy, and the CCG representatives acknowledged the progress made and the depth of the change.

6.5 There are a wealth of organisations that are focussed on supporting the families perspective, that may well welcome an opportunity to provide some training or advice to the Trust on skills for working with families:

<http://www.avma.org.uk/>

<http://aafda.org.uk/>

<http://www.hundredfamilies.org/>