

**REPORT OF EXTERNAL REVIEW OF SAFETY AND CLINICAL
GOVERNANCE ARRANGEMENTS WITHIN THE
SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST
DECEMBER 2010 – JANUARY 2011**

IN STRICT CONFIDENCE

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SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST

Revisions to correct inaccuracies on pages 2 and 33 made 9/5/2011

External Review of Safety and Clinical Governance arrangements

REPORT OF TEAM REVIEW

1. Introduction

As a result of the tragic death of a 19 year old male in-patient (JR), who was found hanging in the en-suite shower room on Southgate Ward on the 29th August, 2010, and other concerns, NHS Suffolk (NHSS) PCT and the Suffolk Mental Health Partnership Trust (SMHPT) convened a review into patient safety at SMHPT.

Prior to the JR incident, between May and August 2009, a cluster of five homicides involving individuals known to the SMHPT had occurred. The Trust had commissioned an independent team to undertake a documentary examination of the five incidents. The review team produced their report in December 2009 and identified a number of high level concerns in respect of systems and clinical leadership and made recommendations to address the deficits. We have used this report as a reference point for our own appraisal and in particular, to measure progress in actioning the recommendations during the past 12 months.

Performance Notice

At the start of 2010 NHSS had identified deficiencies in their serious incident reporting monitoring processes, and had worked on improving this which meant that the PCT was better able to detect clinical governance issues, and that a number of SMHPT serious incidents were not in a position to be appropriately closed down. Following a number of concerns about the delivery of final reports and action plans within an agreed timescale, NHSS issued a performance notice to the SMHPT dated the 14th October 2010. The performance notice stated that the SMHPT was not adhering to the standards set out in the East of England SHA *Serious Incidents Requiring Investigation Policy*, in particular, that of the first 10 SIRI's reported in 2010, 9 had not been completed within the 45 day timescale. A remedial action plan was prepared on the 29th October, which is currently being monitored through the contract monitoring process.

It was clear to the review team that both the PCT and the Trust were keen to be reassured that the systems, processes and practice were such that those using the services and their families, along with managers and staff, could be confident in the safety and effectiveness of the service provided.

Patient safety is a major issue of concern within all acute mental health services. The broad Terms of Reference required us to examine all aspects of delivery. In the limited time available we have primarily focussed on the Adult Acute Services rather than adolescent services, services for older people with mental health problems, or individuals with a learning disability. The review team was commissioned at the beginning of December 2010 to provide a report within six weeks.

The time available for the review was therefore very limited, taking into account the size of the organisation, the geographical spread of services and the timing of the review coinciding with the Christmas holiday period. A further complication was extreme weather conditions

and the illness of the Chair of the review team. Despite these challenges, the review team feel confident they are able to make recommendations based on detailed information and findings that should enhance the safety and effectiveness of the services provided by the Trust.

2. The Review Team consisted of:

Malcolm Rae – OBE, FRCN

Dr Stephen Colgan, Medical Director and Consultant Psychiatrist Acute Care, with the Greater Manchester West Mental Health NHS Foundation Trust

Dr Michael Doyle, Nurse Consultant, Clinical Researcher and Programme Director, Greater Manchester West Mental Health NHS Foundation Trust & the University of Manchester

Sara Fletcher, Deputy Director of Patient Safety and Clinical Quality NHS Suffolk

3. Terms of Reference

The aims of the review were to:

- Provide NHSS and SMHPT Boards with assurance as to the competences and effectiveness of patient safety and clinical governance arrangements and systems (including structures, process, attitudes and practice standards)
- Identify any deficiencies in patient safety and clinical governance arrangements and make recommendations to rectify these
- Identify service strengths and positive practice
- Bring ideas and good practice from elsewhere for adoption across the Trust as a whole

4. Methodology

Our principles were:

To distinguish between fact and opinion / comment

To listen carefully to what was said

To be open, fair and as objective as possible in our deliberations and conclusions

To avoid being biased by hindsight

To judge the care and treatment according to evidence based practice or recognised positive professional standards and national guidance

To use reasonableness as our yardstick when deciding on what or was not a satisfactory or an acceptable standard of practice

5. Key Questions

Some key questions were used to provide a framework and focus for our analysis

- Is the environment safe? This included the physical environment itself, number of beds, client groups served ward layout, staffing levels and any other environment issues
- Are the correct policies, procedures and systems in place and in good order and available so as to provide a safe therapeutic environment? This includes the whole range from clinical leadership, effective management, record keeping, assessment and treatment plans, the management of ligature risk, observation and engagement policies and practice, handovers, supervision and training activities and therapeutic programme and the effectiveness of MDT working and the therapeutic milieu
- Were the actions carried out by the Trust following each incident sufficient?
- Could we identify any gaps in the action taken or planned by the Trust?
- Was there any further action required by the Trust?
- Are there any recommendations or suggestions to improve the systems of care and treatment, the culture, morale, leadership, relationships between staff and other agencies?
- We were also keen to identify positive aspects that could be further developed.

We initially conducted a thematic review and analysis of the reports of serious untoward incidents over the past twelve months. In particular, the report from an external-independent team, following a documentary review of a cluster of homicides in Suffolk between May and August 2009, allegedly involving people having an association with services offered by the SMHP.

We also read a substantial number of Trust policies, professional guidance and accessed current evidence of positive safety practice.

This preparatory work was helpful in enabling a comprehensive understanding of the structures, systems processes, attitudes and practice; both at the time of the cluster of incidents and subsequent action taken by the Trust to prevent similar incidents. It also enabled the review team to test out and triangulate some of its early observations and initial concerns after reading the documentation.

We then embarked on a programme of focused semi-structured interviews with a cross section of key clinical and managerial staff, and we also met with current service users and their representatives. We had a positive meeting with a local G.P., who has a special interest in mental health.

The interviews were designed to 'test out' some of the emerging themes from the various sources of information and for us to generate information and ideas from the interviewees own experiences, observations and insights.

Where time was limited, we invited members of staff to respond to both prepared questions and to share with us additional concerns or examples of positive practice. This proved to be very productive with some individuals providing a group response, having shared the questions with their team colleagues.

We also organised a 'focus group' with the modern matrons to capitalise on their experiences, as they are a key group in overseeing safety issues.

We undertook site visits to enable a better understanding of the environment and physical structures and layout and to help us appreciate the problems in ensuring safety. This included, experiencing a new style handover on Southgate Ward.

6. Preventing suicide and violence

National guidance has recently been published promoting best practice in preventing suicide (National Patient Safety Agency (NPSA), 2009) and managing risk generally (Department of Health, 2007). In addition, there is an emerging evidence base supporting good practice in enhancing the safety of service users in mental health services.

We have provided a summarised overview of a range of literature relevant to this review in Appendix 1. The key findings are summarised below to provide contemporary information on best practice that should help in-service development, monitoring and evaluation, as well as informing future training programmes.

Summary

The literature review emphasises the importance of the following factors to support suicide prevention, reduce risk of violence and enhance safety generally in mental health services.

- Recognition that all service users in the mental health system are at risk of self harm
- Training for staff in suicide and violence prevention as well as risk assessment and formulation.
- Clear observation policies.
- Established staffing levels with minimum use of agency or staff that are unfamiliar with the ward.
- Therapeutic engagement balanced with surveillance.
- Staff to receive regular clinical and managerial supervision.
- Maintenance of a safe environment and the removal of ligature points.
- Best use of the layout and structure of the wards to promote observation and staff engagement.
- Structured professional judgements are recommended.
- Multidisciplinary assessment, formulation and management are encouraged.
- Service user and carer involvement in assessment, formulation and management.
- Proactive measures such as rapport building, developing therapeutic alliances and regular 1:1 time are crucial for preventing risk.
- Monitoring of signature risk signs may help in preventing risk to self and others.

7. Analysis and Approach To SIRI'S / SUI'S

Different terminology is consistently used across the Trust. Serious untoward incidents (SUI's) and serious incidents requiring investigation (SIRI's). For ease of consistent understanding we will use the SUI terminology. The mixed terminology arose following the NPSA in March 2010 changed the terminology to SIRI.

We received a substantial number of serious untoward incident reports, both 7 day and the 45 day internal investigation reports. Overall it appeared to us that there was an improving position with a more consistent and reasonably rigorous methodology being regularly adopted by those leading the internal SUI processes.

We believe the remedial action plan has galvanised the Service and resulted in an increased assurance that actions taken to achieve improvement has occurred.

Some of the reports were exceptionally detailed and in one instance with the full involvement of a range of multiagency services. We were impressed with the template of the standard report sheets, which also act as a guide and prompt for those leading the review. Most of the reports succeeded in identifying issues of concern, with just a small number not fully doing so.

A root cause analysis and identification of contributory factors approach is now followed. We noted the use of a chronology and timeline and recording of support to families and patients, together with support for staff involved from their line managers. The latter is to be commended.

However, we also noted some concerns reflected in comments and feedback from the PCT whilst monitoring the process. These concerns included:

- No deadline dates for delivery
- Root cause analysis and associated causes not always explored in sufficient depth
- Documentation, on occasions required greater depth or clarity regarding titles and occasionally more sensitive language

We were also informed by both nursing and medical staff of a positively received initiative, a patient safety workshop aimed at raising awareness of lessons learnt from SUI's.

The areas requiring further development are the timely tracking and monitoring of progress, and evaluation that the actions arising from the key recommendations have actually achieved the objective intended.

In particular, greater attention needs to be given to sensitive feedback and continued support for those involved in SUI's and the sharing of lessons learnt across the whole Service. This is also a concern in many other parts of the country. The Trust should resolve not just to share the outcome of incidents but to apply the lessons learnt across the organisation. To assist this process we have provided at Appendix 2, some suggestions for improved dissemination, shared learning and implementation.

A substantial number of those we interviewed commented on a lack of awareness of outcomes of SUI's even when they had been involved. A further issue of concern raised with us is that some staff fear being blamed as a consequence of the SUI. The Trust should consider this in terms of training for those engaged in leading SUI investigations. We understand that the Trust SUI policy states "the Trust promotes a non punitive approach towards incident reporting". However a 'fair blame' policy should be more vigorously developed, in line with NPSA guidance.

It would also be of benefit if the Governance arrangements enhanced the existing process of analysis and identification of common themes, trends and problems within systems and practice and these were discussed and actioned at governance and clinical meetings.

The Trust should further develop the means of incorporating lessons learnt back into the organisation as a whole, by improving sensitive feedback, giving local ownership to the improvement, monitoring and evaluation of progress and to continue the positive initiative of organising patient safety events.

8. The Report Of The Internal Investigation Into The Care and Treatment of Mr JR, who died on the 29th August 2010 whilst an inpatient on Southgate Ward

In our view, this was an illuminating case study identifying poor quality care, support, treatment and supervision of JR during his admissions and at the time of his initial discharge.

Regrettably, we only received the above report after the end of the second day of interviews. Earlier possession of the report would have enabled us to have asked additional questions of those we interviewed during the first two days, and for us to have had a greater understanding of the nature of the concerns. It is likely this would have enabled us to have planned the review in a better more informed way. Nevertheless, we have subsequently been able to use the reports' findings in our appraisal of the safety and governance concerns.

The JR investigation was impressively carried out by Robert Bolas, Director of Nursing, who acted as the Chair of the Panel and fellow panel members Dr John Bellhouse, Consultant Psychiatrist, Acute Service and Jane Coates, Modern Matron, Later Life Acute Services.

Their investigation had many commendable features, including:

- It was remarkably insightful, honest, detailed and comprehensive in its analysis and critical findings.
- The use of the NPSA 'RCA' methodology for investigation in particular, the key contributory factors, recognition of good practice, use of a chronology
- The detailed history of the deceased
- The supporting explanatory information to help the reader have a fuller understanding of a personality disorder diagnosis, and NICE guidelines
- The number of and range of disciplines involved in JR case who were interviewed
- The connection with JR's family after his death
- The reference to a range of National / Department Of Health guidance and reports
- The appendix describing the timeline of the anti ligature policy and process for Northgate / Southgate Wards
- The detailed and appropriate recommendations and action plan, with a lead person and target date being identified

Although the above positive points are noteworthy, we were disappointed in the delay in the implementation of some of the recommendations.

Some of the recommendations and actions required substantial resources and time to achieve. When we visited the Southgate and Northgate Wards within the Wedgewood Unit, there were a number of safety issues which we consider should have been prioritised and addressed much sooner.

To their credit, the service had speedily responded to modifying the shape of the door and door handle, concerns identified in the JR report, and they had developed a new system of ligature audit to assist in prioritising remedial action. However, multiple ligature points remain. They include; windows, window handles, wardrobe doors, bed frames and taps.

Plans are underway to assess the risk of ligature points, but the ligature risks in service users bedrooms do not appear to have been mitigated by enhanced physical, procedural and relational safety measures. Additional staff are only provided for special observations. We also believe that the garden area is vulnerable due to the low fences, moveable garden furniture and low roofs.

Due to human ingenuity or lack of an adequate technical solution, it is not always possible to address all ligature points. The ward design, in combination with the presence of multiple ligature points in bedrooms and other unsupervised areas, means that the current vulnerabilities of the ward should be reviewed as soon as possible.

It is acknowledged, that some remedial work to remove the ligature risks will take some time to achieve. There will be cost pressures and implementation difficulties; for example, replacing windows and doors. Other risks may be managed relatively quickly following ligature risk assessment and a review of the wards operational policy, i.e. wardrobe doors.

In these circumstances, a comprehensive review of the ward operational policy is required to increase physical, procedural and relational safety and security. A review of this nature requires the full support of the Trust Board.

We immediately informed the Trust Chief Executive of our concerns and we made some early recommendations to reduce the risks and improve the safety.

The recommendations were:

- To have daily inputs to the wards from the Consultant Psychiatrist or their deputy to oversee the review of the risk plans and any emerging patient safety concerns.
- To develop more systematic shift handovers that includes medical staff, and cover the full name of the patient, diagnosis, M.H.A. status, observation level, leave status, presenting risks and relapse signature risk signs, current treatment plans and current mental state.
- To reduce staff to service user ratio by more staff and / or reduced beds
- To have more frequent checks on the whereabouts of service users

- To conduct the NPSA '*Ward Managers Checklist*' as soon as possible and at least monthly thereafter
- To proactively improve relational safety through daily 1:1 sessions between service users and nursing staff, which are clearly structured and documented in the clinical notes and contribute to care planning and effective clinical management. We suggest that 1:1 time could occur in various forms, for example, short conversations, recreational activity, social interventions, escorted trips, all aimed at engaging and communication, and gives the additional opportunity for observation, assessment, motivation and the building of therapeutic and trusting relationships. The activity and time involved should be tailored to individual needs and presenting problems
- To ensure all service users have a personal risk formulation in addition to risk rating identification and implementation of a relapse signature risk signs checklist, to be used to monitor early signs of risk. This should inform clinical judgements and signature risk signs should always be considered prior to leave or discharge
- To establish a reflective practice group, peer reviews and co-working with service users who present with difficult and challenging behaviours

Once our concerns were shared with the Trust, we were very impressed with the Trust's response to the recommendations. The day following our visit to the wards we brought our concerns to the attention of Mark Halladay, the Chief Executive, who involved the Acute Services Manager, Margaret Little, and together they immediately set about implementing the required changes.

On his return from annual leave, the Director of Nursing and the Chief Executive both visited the two wards and discussed the concerns and actions required with the clinical teams. On the 30th December, we received from the Director of Nursing an extremely comprehensive and detailed action plan to address the concerns identified. In many ways the plan is an extension of the recommendations of the J.R. investigation. The action plans included immediate mitigating action, future action plans, a date for completion and an identified responsible lead person.

We also noted the positive initiative the Trust adopted in bringing the concerns and the Trusts response to the CQC compliance manager.

The action plan target dates clearly go beyond the duration of our review and we urge the Trust to keep progress under a sharp focus with regular monitoring and evaluation.

In addition, we recommended for medium and longer term development, trust wide action to monitor, evaluate and embed patient safety initiatives. These include:

- To revisit the Trust policy for individual and personal property searches for in-patients to ensure regular monitoring of service users belongings. In our communication with the Trust we urged that this includes a policy for mobile 'phones, as the charger cords have been used to self harm elsewhere. We also

advised of the potential problems of service users reacting to conflict or negative calls or text messages

- A senior team including a Senior Manager and a Ward Manager to complete the NPSA **General Audit Tool**. We believe this will provide a comprehensive measurable view of the Trusts performance against best practice standards for suicide prevention, which should lead to the development of an action plan to address any concerns
- The audit should coincide with an overall suicide prevention environmental survey. All internal and external areas, materials, premises, fixtures, fittings and equipment that may increase risk of self harm should be identified and risk assessed. This should involve a repeat of a ligature survey and planned ligature risk assessment, with a view to ensuring that all ligature points are removed, covered up or managed, with bedrooms and other unsupervised areas being a priority.
- We appreciate this will bring many financial and organisational challenges, however, the executive group will need to discuss ligature issues in a strategic and systematic way. They will need to make sure their discussions are informed by regular audits and stock takes, identifying the most serious and current risks, ensuring they are then aligned to the estates strategy.
- The Trust should develop a suicide prevention steering group aimed at developing a Trust wide action plan to minimise the rate of attempted and actual suicide. This group should have clear terms of reference and have a membership that includes a Trust Executive Director as Chair; representatives from Governance and from all clinical disciplines, Senior Managers and a Senior Manager from Estates / Facilities. Consideration should also be given to inviting external persons to attend, who may be able to provide impartial and alternative perspectives
- Increased frequency and monitoring of suicide prevention and training, that includes consideration of real life case examples followed by supervised practice to ensure learning outcomes are achieved
- To develop a Trust-wide personality disorder policy
- Review the operational policy of the CRHT to ensure compliance with policy implementation guidance and current best practice

We were reassured with the prompt and positive intention of the Trust to take forward these initiatives. We affirm and add to these suggestions later on in our report recommendations.

9. Analysis of incidents arising from previous serious untoward incidents

We thought it sensible to identify the common themes and issues arising from the cluster of homicides report in December 2009, other SUI's over the past 12 months, and where possible assess the Trust's response to the findings and the effectiveness of lessons learnt

and shared action plans. We therefore received a substantial number of internal investigation reports and we give below our summarised findings.

These are listed in a headline form to advise the reader of the range and scale of issues to be addressed. Many of these issues of concern speak for themselves. We subsequently added to the list of concerns identified in the J.R. review completed in December 2010. These concerns may be used by the proposed suicide prevention steering group to benchmark against or in prioritising future audit and professional development programmes.

Common themes and issues of concern included:

- **Record keeping, including;**

- Not compliant with Trust's records guidance
- Medical notes were criticised
- Not enough justification for opinion and thinking
- Not comprehensive and sufficiently detailed in explaining behaviours
- Medical records not used in handovers
- Difficulty in locating relevant information
- No risk management plans
- Dual paper and electronic clinical notes, leading to confusion on reliability of current records
- Records unsigned, not attributed or dated
- Difficulty in identifying the patient from some of the paperwork
- Medical notes not available arising from Section 136
- A lack of clear documentation of joint assessment between doctor and AMHP
- Next of kin not recorded
- Variable compliance with Trust record keeping standards
- Inability to access electronic records between key services
- IAPT and Compass – social records not accessible
- CAMHS notes not immediately available
- Unclear how HCA contacts are countersigned by qualified staff
- An episode of notes being shredded

Electronic records, including:

- Some medical staff not using
- Duplication with paper records
- Not fully capturing comprehensive history
- Some forms in paper records incomplete

Risk Assessment / Management including:

- History taking not being comprehensive and a lack of rigour
- Too much reliance on individual assessment and not enough team discussion
- Alcohol and drug misuse not given sufficient weight or included in risk management plan

CPA and Care Planning, including:

- Crisis contingency plans not always in place
- MDT Care plans not always established soon enough
- Poor discharge planning, care coordinator not involved, poor communication

Clinical and Managerial Supervision, including:

- Supervision of junior medical staff
- Some social workers not receiving supervision
- Supervision structures unclear and variable picture of how supervision worked on the ward

Management and Care with people who have borderline Personality Disorders and present with Challenging Behaviours, including:

- Staff ill equipped to deal with challenges of increased numbers of service users who have BPD characteristics
- Training and supervision
- Absence of appropriate care pathways, strategy and specialist services
- Inappropriate admissions (including JR)

Referral Systems, including:

- Delays in responding
- Communications with referrers: GP's, "having to refer back time and again found system difficult and confusing"

Role of CRHT, including:

- Problems in gaining access to beds
- Referral back to GP for M.H. Act assessment
- Age limit – What alternative or advice given to referrer and family?
- Relations between in-patient staff and CRHT described as difficult and teams were perceived as operating to their own objectives rather than services as a whole
- Overloaded with inappropriate referrals
- Lack of liaison between East and West (see later)

Accident and Emergency Liaison

- A need for training in risk assessment skills
- A lack of awareness on mental health conditions by A/E staff
- Awareness of safeguarding policy

Child and Adolescent Mental Health Services, including:

- Procedure for transfer to Adult Services
- Transfer to other Trust services

Ligature Policy, including:

- Assessment not actioned in safe, effective and timely manner
- Inadequacy of management process
- A lack of clarity of interpretation in identifying en-suite door handles separate to bedroom door handles
- No clear time tables for the actions to reduce the high risk areas identified.
- No Managers appear to have been involved in decisions around risks in their respective area

Clinical Governance, including:

- Audit – Considered as weak, patchy and inadequate
- Timeliness in reporting

Management and Leadership, including:

- Supervision of junior doctors
- Job plans and reviews

Multi Disciplinary Team Working, including:

- Records
- Lack of discussion re the management plan of service users misusing drugs

Carer Assessment:

- Delays in Carers Assessment

Safeguarding, including:

- Negative exploitative relationships were not fully discussed or acted upon
- Delays in accessing CAMHS notes to assist comprehensive understanding of patients history and needs

Polices Procedures, including:

- Adherence
- Awareness and understanding

Practice, including:

- Clinical assessments not always systematically captured
- Not enough therapeutic activity
- Discharge processes
- Insufficient attention given to practice development and training

Education and Training, including:

- A lack of training and development opportunities and problems, in particular:

- On mental health conditions
- For health care support workers
- For personality disorder and substance misuse
- Learning on the job
- Staffing levels and workload impede access to training
- Pressure to achieve mandatory training with current compliance only variable

Substance Misuse, including:

- A lack of clarity around the role of the link worker
- Staff felt unable to apply Zero Tolerance Policy, as they felt unsupported by members of the MDT, the Trust and the police. Also, conflict in setting boundaries between in-patient staff and the AOT

Safety Culture – Managing Risk – Operational Factors

- A lack of clear, robust Trust processes, which is understood by all
- A lack of clear guidance for staff on drug and alcohol screening for all patients and support to do this, and the interventions if action is needed to be taken
- Staff felt disempowered to apply policies (Zero Tolerance)

Police Liaison, including:

- A lack of agreement with the police to provide support to the wards, especially in relation to a regular police presence and dog searches
- Different approaches and levels of support offered in the East of the county. In the West, difficulties encountered in the police support for service users misusing substances and the availability of sniffer dogs.

10. Findings, Analysis and Recommendations

Introduction

It is important to have an understanding of the background and appreciation of the context of the Service organisation during the past eighteen months.

The Service has been subjected to massive changes over the past few years, beginning with the merger of Trusts a number of years ago with associated problems of different cultures and ways of doing things, professional rivalries and a reluctance to fall in line with the new consistent approaches expected. The difficulties of merging have been exacerbated by problems of recruitment and retention and relationships with universities.

Throughout the past few years the Services have been subjected to a range of modernisation initiatives. The demands on the Executives time and focus of submitting two applications for Foundation Trust status and being scrutinised and tested by monitor has placed a strain on the Trust Board.

More recently, the proposed merger with the Norfolk and Waveney Foundation Trust will have consumed enormous energy and time of the executive team.

In addition, the planning and commissioning of the new build acute unit will have absorbed the time and resources of the clinical staff.

We understand there has been a plethora of other initiatives including, service line management, productive wards, e-rostering and NHS professionals: staff assert they are 'flooded with requests for information'. It seems to us that these many organisational and service change initiatives have impacted on the morale of staff. They reported feeling pressurised, overwhelmed and uncertain, not always informed or involved, that excessive change had not always been allowed to become embedded. This had resulted in a widely held perception that the Core business of delivering safe, effective care and treatment has been somewhat eclipsed by the managements goals and imperatives of the Trust's growth and survival. We have been informed that the J.R. incident resulted in staff experiencing severe stress, some requiring medical treatment.

Likewise, senior management time can be readily absorbed in delivering to external agendas and to the various regulators, who often require vast amounts of very similar information, but in subtly different formats. In these circumstances the 'day job' i.e. running safe and effective services can easily lose their primacy e.g. Mid Staffordshire. The requirements of an effective organisation are to have a clear vision of what is to be achieved (which must be high quality services), a strategy to get there, to have a sequential order, and to be able to prioritise effectively at times of stress. Clearly the senior management team cannot do this task alone, and needs support from all its clinicians, especially the consultants. Communication and involvement is vital, with sharing of the vision.

Medical Staff

A previous external review of a cluster of homicides in December 2009 when identifying high level concerns had remarked, "*Managerial oversight of clinical practice and audit of same as inconsistent, particularly with regard to medical practice*". Also, "*Medical arrangements pertaining to Governance responsibilities for medical clinical practice standards appear weak*", and in their conclusions referred back to the Bristol and Alderhey Inquiries and to the fundamental significance for the patient safety in this regard; there must be no confusion about the issue of self regulation and accountability.

In drawing similarities with the Suffolk Mental Health Service they highlighted problems with governance and leadership and commented "*There were also serious flaws in attitude and behaviour*".

In our view, little has altered since then and there was evidence of resistance to change on the part of a number of medical staff, with significant efforts to block management and undermine the recently appointed Medical Director.

We also noted the JR internal investigation identified concerns in respect of the allocation of junior doctors and a lack of cohesion between the medical staff. We give below our findings and reflections.

We were told by non medical staff, that there were many positive examples of effective senior clinical leadership and full involvement in effective MDT working, particularly so in the East. However, we were also advised, that in the West part of the Trust, specific consultant medical staff were not fully committed to new ways of working nor did they

provide the necessary leadership and support to colleagues or active involvement in patient care delivery decision making.

Medical staff we interviewed asserted a number of grievances and concerns including:

- Being overworked and unsupported
- Requests for central support regarding junior medical staff not forthcoming
- Junior staff cover unevenly distributed
- Too much use of locums and agency doctors
- Human Resources had been an impediment to timely recruitment
- Concerns re capacity of CRHT, which had led to delays in discharge
- Low level medical work, i.e. clerking, discharge summaries etc, having to be carried out by consultant staff
- Little time for reflection or engagement in strategy
- Working in the West induced feelings of isolation
- A lack of cohesion and coordination
- Concern regarding the use of both electronic and paper records, which could lead to duplication and errors
- No team training in how to manage the challenging behaviours of service users with a diagnosis of personality disorder, especially in the community
- Research and Development and audit not adequately promoted
- Inequitable mix of consultants between the East and West
- Access to CAMHS a problem; concern expressed; only became aware of abuse and safeguarding concerns after SUI

It was not possible to verify or pursue all of the concerns raised. However, we did note the apparent lack of development of appropriately qualified Advanced Practitioner or non medical prescribers to support consultants and which would go some way to ameliorate withdrawal of traditional junior medical support through the European Working Time Directive and new training requirements.

We were consistently advised that the recently retired Medical Directors strengths were not in medical leadership or management. We were led to believe that he had developed the role idiosyncratically with a focus on business orientation, and had been detached from delivery and evaluation of clinical care. We were also told that he was very supportive of medical interests in general and consultants in particular. A number of idiosyncratic practices had been allowed to develop with regard to job planning, which were not always in the best interests of the service.

We were told that the core or standard consultant job plan consisted of 7 PA's for direct clinical care and 3 PA's for supporting activities. In lay terms this means that 70% of their time is spent in treating and managing patients and 30% on supporting activities, e.g. research, continuous professional development etc. If this is accurate, it is a generous split in terms of national guidance 7.5 – 2.5

We were informed that job planning occurred at consultant appraisal. Appraisal is a formative activity, usually undertaken between peers. It is time for a consultant to reflect on their practice, and develop a programme of training activities for the forthcoming year. This

is not a meeting between a line manager and employee, and it is far from clear as to how effective job planning can take place in these circumstances.

We were left with the impression that the job planning arrangement occurring at appraisal has been a 'somewhat cosy practice', without challenge or linkage to the Trust's clinical governance or managerial and service strategic objectives.

It also appeared to us there was some confusion on the part of the consultant medical staff as to the role and function of a Medical Director, i.e. to act as an advocate for medical staff, or a Board appointment with joint responsibilities and corporate liability for the operation of the Trust.

There appeared to us a need for medical staff to be managed, but it was not clear as to how the consultants were brought into the process. From the consultants' perspective, there was a consensus that strong medical leadership had historically been lacking. Paradoxically, when a strong leader was appointed he was undermined by some of his senior colleagues. We consider that when the new Medical director, Dr Lowe, who had significant prior experience, in an award winning foundation trust, was appointed, he quickly recognised the somewhat outdated practices in Suffolk and attempted to make the necessary changes.

This appears to have galvanised the consultant body, which held an extraordinary meeting to discuss Dr Lowe's approach. The conclusion of this meeting was the production of a '7 point letter' to the Executive identifying a number of short comings of the medical director, and consideration was given to reporting him to the GMC with expressions of concern over his health. The summary view from senior medical staff was that the Trust had been effectively told what they would tolerate in terms of management, and to proceed in this manner could result in further dissent, and possibly loss of confidence in their senior management team.

In our view this was unprofessional and unacceptable behaviour from the senior medical team. Dr Lowe required significant senior support at this time to manage a very difficult situation, and one that he had been specifically recruited to address. Unfortunately he appears to have been let down.

We were pleased to note that following an independent review, Dr Lowe had been completely exonerated and had now returned to take up his duties. It is regretted that his forced absence of three months prevented Dr Lowe making the essential changes to medical management and leadership we consider are necessary.

A further concern is that one progressively orientated consultant we interviewed, who in other ways was impressive, was not able to identify any clinical governance processes in the Trust other than being involved in an SUI. As such, there appears to have been no learning from clinical incidents.

The Medical Advisory Group (MAG) was described to us as a relatively active group that met separately in the east and west, there is also a trust wide group. This group had an agenda with a number of management items included. However, it was not made clear to us how or if the (MAG) was accountable to anyone or how it connected with Trust management structures. We were informed that the CEO attended by invitation only, but this occurs on a regular basis and includes the Associate Director for Psychological Services. This

arrangement gave the impression of an organisation within an organisation, wielding power unaccountably and possibly without responsibility.

It appears to us that despite positive and rigorous interviews to appoint service line leaders, those involved did not have a depth of understanding of what it meant for them personally or professionally.

We were also concerned to receive comments from a consultant that, "The ward is a disaster zone" and "One should be surprised that more incidents are not occurring". The same person described his role as 'fire fighting'.

We were advised that in the CAMHS Service, in some instances management and supervision of caseloads was required. It was suggested that some CAMHS caseloads were kept open "just in case", a limited monitoring role, without any meaningful intervention.

Much of the above is worrying, especially when we cross referenced with the outcomes of our interviews with non medical staff.

A number of staff talked at times explicitly of the lack of involvement of medical staff in the managed operations of the Trust.

It appears that many functions had developed, e.g. governance and audit without any senior medical staff involvement. Various staff had struggled against this but with little success. We were told that recently when concerns over a consultant's behaviour had been raised through the medical hierarchy, that these had largely been dismissed, which had resulted in considerable distress and sickness leave on the part of a respected senior manager.

The impression we have formed, and one that clearly needs to be further explored in the new management arrangements after the proposed merger, is that some members of the consultant group, who initially appeared ill organised and disengaged, are actually a very powerful force maintaining the 'status quo'. They operate a parallel management structure, which is unaccountable, and not tied into Trust strategic objectives and we presume to be driven by vested interests. Non conventional means are used to undermine or dismiss management initiatives and assertively disrupt line management of themselves. We believe this is to the ultimate detriment of the Trust and patient care.

We consider that consultant job planning has no challenge or rigour. This is usually a significant professional event, which is expected to effectively manage expensive resources (and public funds). Furthermore, the Trust appears to have no (effective) structure or mechanism through which it could manage the consultant medical staff.

Arising from these concerns we have formulated some specific recommendations.

Recommendations:

1. To undertake a review of medical leadership and management. This should lead to appropriate structures to support professional management of all doctors, and to support revalidation. The medical hierarchy should have a significant role, if not leadership, for clinical standards and governance. This would be in line with requirements for medical revalidation.

2. Clear and appropriate job descriptions for all consultants identifying their involvement as senior clinicians in all aspects of the Trust's functions e.g. clinical governance and service development.

3. Clear job plans, in line with national guidance, identifying appropriate time allocations to support 2 above. The job planning process to be significantly modernised, and identified separately from appraisal/revalidation. Consultant job planning should involve a senior manager, with resource allocation responsibilities, introducing challenge and rigour. All job plans should aim to be compliant with EWTD, and support Trust strategic objectives. All consultants should be fully accountable and demonstrate the highest standards of probity and good medical practice.

4. Modernisation of the work force, including the development of Advanced Practitioners and non medical prescribers to support consultants following withdrawal of traditional junior doctor support (through EWTD and training). These developments to be undertaken in tandem with consultant job plan review to identify where they are most needed. Consultants should not be expected to act as 'sweepers', absorbing all work not done by others.

5. To develop agreed terms of reference for the Medical Advisory Group. If this is to have a formal role in management of the Trust, then it needs to be appropriately accountable, and tied into Trust processes. An alternate route would be for the MAG to seek advice from the BMA, which provides a model constitution for Medical Staff Committees (MSC). In these circumstances the Local Negotiating Committee (LNC), is a formal sub committee of the MSC/MAG, which the BMA industrial liaison officer attends. In these circumstances the role and function of the MSC is much clearer, canvassing and representing consultant views and interests through the joint meetings between the staff side and management team at the LNC.

6. Develop processes to 'talent spot' and support succession planning in medical management. This should include nurturing young talent who have

an interest in or aptitude for management, through training and clearly identified time in their job plans.

Information and Communication Systems

The JR internal investigation had highlighted considerable problems with communications. In particular, not all records were stored together or easily accessed on the ward.

Both paper records and ePEX electronic record systems are used on the ward. It had been acknowledged by the ward manager that there were problems with running both systems. It had also been acknowledged that the ePEX system was not used in handover. It had been confirmed that daily contacts were recorded on the ePEX system and medical notes were not used in the handover process between shifts. The J.R. SUI investigators had identified a clear gap in the transfer of information to support effective communication.

Also, problems had been identified in locating relevant information within the records, and forms within the paper records were incomplete. Nursing records and medical records did not indicate a clear management plan in responding to JRs care needs. Little evidence of one to one's, nurse patient activity with JR was noted.

A significant number of individuals drew our attention to the lack of joined up communications systems.

Recommendation:

There needs to be a records strategy to move to a single (electronic) patient record. Continuing to run dual record systems is an unacceptable risk. This would include a date when paper records would be withdrawn

Recruitment and Retention Concerns

The problem of recruitment and retention of experienced qualified staff was identified in the internal review of JR, which highlighted that the high turnover, increased vacancy rates, and use of temporary staff impacts adversely on risk and safety, in particular team cohesion, communication, leadership, knowledge and competence and the ability of the team to provide the necessary support and supervision to a complex patient mix.

The problem was also highlighted by many of the staff we interviewed, particularly from the West Sector of the Trust, who described persistent difficulties they had in recruitment. They also expressed their considerable frustrations with what they perceived as inadequate support from HR in remedying the difficulties. Staff based in the West regarded themselves as disadvantaged in comparison with services in the East. They complained about having to rely on substantial numbers of bank and agency staff to get by.

We were pleased to note that at the time of our review the vacancies had diminished and the appointment of new staff was in the pipeline. The problem of recruitment of experienced staff remains.

Recommendation:

The Trust should take note of the concerns expressed, explore in more detail the issues and develop a more effective approach to the recruitment of high calibre staff

Service users with a diagnosis of personality disorder (PD) who present with complex challenging recurrent behaviour problems

It appears that there are an increasing number of service users with unstable personalities, who lead chaotic and stressful lifestyles, who struggle to adjust to changing circumstances, have social relationship difficulties and engage in higher risk substance misuse with a propensity towards impulsive self harming behaviours; often their social and mental health needs and problems require the interventions of a range of interagency services including Housing and CJS. Some of those individuals who featured in the cluster of homicides and other SUI's that we read had a diagnosis of personality disorder.

There is evidence that many staff are ill equipped in terms of awareness, knowledge, skills interventions and confidence in responding to the often high risk behaviours and tensions. It was by far the most common concern raised with us by both inpatient and community staff of, how best to care for and manage challenging and risky behaviours.

It appears that there is no established interagency strategy or care pathway for individuals who present with Borderline Personality Disorders (BPD). However, we were told by the PCT an initial strategy is being developed.

It is well known that people with personality disorders can have a negative impact on teams. Often, the assumptions and inferences clinical staff draw from service users' behaviours influences their responses, for example, speedy discharge. More extreme behaviours drive more extreme judgements and emotional reactions, which makes it hard for clinical staff to think through or problem solve effectively. Recent SUI's have exacerbated the anxieties of staff, leaving some clinicians feeling exposed and vulnerable, and this could lead to defensive, risk averse practice.

Often, some staff believe there is little prospect of effecting real change in mental health inpatient facilities or community services. This in turn contributes and compounds feelings of hopelessness and may lead to self harming and suicidal behaviours in service users. Other staff, assert that service users should not be excluded because of their diagnosis, which may often be a presentation of multiple problems.

It is vital for clinical staff to understand the function of the behaviours exhibited and how they link it to underlying personality disorder characteristics.

A non judgemental, descriptive approach to service user behaviours is likely to be helpful, as is having space to explore differences within the team, that lead to splitting. This is particularly important where professional boundaries are challenged and staff support and supervision is crucial to contain anxieties.

Of note, we heard from a number of sources of a fairly recent initiative from Psychologists who are working with clinical teams to provide supervision and supportive inputs. All those involved commented enthusiastically on the benefits of this.

It would be inappropriate for us to advise the Trust and the PCT how the Service should manage service users with personality disorders, which require strategic planning and coherent therapy models within a systematic clinical pathway. This is also a major challenge for other services. The 'NICE' guidance provides the necessary strategies and expertise and points to the critical importance of training and support for staff.

We believe, this is a priority for the Service. To manage individuals who present with borderline personality disorders and associated problems of impulse control, requires senior and skilled clinical input and responsibilities should be shared across the different parts of the service

Recommendation:

We therefore recommend that the PCT and Trust take the lead in developing a broad strategy involving, Housing, Social Services, A/E, the Criminal Justice System, Voluntary Sector and Primary Care Representatives. Those involved should review the clinical management of people who present with a diagnosis of personality disorder and associated challenging behaviours and take into account the problems we have highlighted.

Clinical Supervision

We were informed that there were clear plans to introduce formal clinical supervision for all staff. However, concern was expressed that this was more aspirational than reality and the JR internal investigation identified concerns in respect of unclear supervision structures and a varied picture of how supervision was used in practice.

Related to this, some staff expressed concern about the difficulties in effectively line managing staff due to poor staff-management relationships, difficulties in recruitment and retention and a managerial inertia, where plans and subsequent benefits were never fully realised (see below).

Recommendation:

We recommend that the Trust should review the clinical and managerial supervision arrangements and ensure they are embedded into practice.

Culture – Administrative / Organisational Concerns

A significant number of those we interviewed expressed their concerns and frustrations about the prevailing and widespread culture of 'things not getting done' and action plans not being followed through with minimal cascading of feedback or explanations for the delay.

We were told that despite regular lengthy, time consuming discussions at meetings and the formulation of action plans, that frequently very little happens.

'Support' services were viewed as creating obstacles rather than facilitating progress. The lack of progress on the removal of ligature points was a prime example. Some commented

that it was a battle getting people to listen and understand, in particular about staffing concerns.

These frustrations have led to attitudes of “Why bother to raise issues when nothing gets done”. Also, it was said “It leads to a sapping of morale and a lack of positive orientation”. When asked where the main blockages were, we were told, “With the Directors”.

In communicating messages from the executive team to the services, the lack of response and positive action was raised in relation to risk management issues and the poor utility of the risk register. We were informed that there are concerns related to poor communication of risk management priorities to staff as a lot of things recommended by the Trust Board don't seem to be actioned or operationalised adequately. Therefore a two-way systemic blockage appears to exist. This was evidenced by the fact that the Trust would be unlikely to achieve NHSLA level 2 status due to record keeping, infection control and sharing of information and learning from incidents.

We have speculated,

“Is the problem a capacity issue”?

“Is the magnitude of change deflecting or obscuring their focus”?

“Does the Trust have the right forums in place to coordinate and monitor action”?

“How might the Trust Board members better connect with front line clinical teams”?

We also checked out whether this was due to a lack of positive influencing skills on behalf of senior clinicians. Whilst not reaching any conclusions, we feel the problem is sufficiently worrying for us to recommend this is urgently addressed by reviewing the processes of decision making and monitoring of actions at Board level.

In addition, a Trust-wide communications strategy needs to be considered to ensure staff concerns are heard and acknowledged by senior managers and that positive practice and a culture of learning and sharing best practice is cultivated.

Recommendation:

The Trust should develop a Trust-wide Communication Strategy, which should be regularly monitored

Acute Care Forum (ACF)

Acute Care Forums were introduced in the Acute Care Policy Guidance. They were established to give a specific focus on the development and review of Acute Services.

When they work efficiently they involve all clinical professionals, service users and carer representatives and raise the profile of Acute Care, address problems, support innovation and drive progress.

We were advised that the ACF had 'run out of steam'. Meetings had been cancelled due to insufficient members being present. We consider this is a lost opportunity to promote positive development and give ownership to those involved in Acute Care.

Recommendation:

We therefore, recommend the Trust re-launches the ACF and ensures there are refreshed terms of reference, objectives and membership.

Board Members

We have formed the view that the contribution and influence of some Board members is somewhat underdeveloped. The team dynamics do not appear cohesive. It appears to us that there is an inner caucus of key decision makers. There is a perception amongst many clinical staff and managers that the Board has disproportionately focused on performance, the business aspects, including Foundation Trust status, rather than developing safe, high quality, sustainable care. They also asserted that the merger initiative had not been sufficiently discussed with senior clinical staff. It is with regret that we were not able to meet any Non Executive members as intended due to the time constraint.

Risk assessment and management

The review team were shown completed FACE (Functional Assessment of the Care Environment) health, social and risk assessment documentation, which appeared to be very comprehensive covering 21 pages in total when printed off the Epex system. This included six pages for the care plan, nine for health and social assessment and six for the risk profile.

Many of the staff interviewed, including managerial and clinical staff, expressed their discontent with the FACE assessment tool. We were also informed that medical staff had refused to implement FACE. The discontent appears to be due to the time it takes to complete, the lack of relevance it actually has for structuring judgements about risk and poor links with risk management and care plans. It was described as a 'paper exercise' 'too complicated' and 'gruelling' by those expected to complete FACE. Although there was a suggestion that the 'risk' section of the FACE was welcomed by some, the consensus seemed to be that a tool was required but not necessarily the FACE.

Recommendation:

The Service should commission a task and finish working group with representatives from all disciplines to review the current clinical risk assessment and management policies and procedures with a view to continuing with FACE or exploring an established and/or fit-for-purpose guideline or tool to be introduced as an alternative.

Clinical risk training is provided, although concerns about the FACE tool seem to have diminished the value of this for some clinical staff. Generally, we were informed that clinical training tended to focus on mandatory training with little opportunity for personal development. The training uptake and compliance report identified clear shortfalls in compliance in many areas including safeguarding children level 2 (35%), dual diagnosis (55%) and dual diagnosis intermediate (3%), basic life support (61%) and personal safety (64%). Compliance with suicide prevention training was relatively high with 82% compliance, although staff expressed concern about the quality of clinical risk orientated training as it tends not to be provided by experienced clinical staff and few medics attend. The focus on mandatory training has also led to a feeling that there is a culture of resistance to innovation amongst operational managers.

Recommendations:

The Trust should consider undertaking a training needs analysis to ensure future risk training is tailored to meet the different needs of all levels and experiences of staff.

The Trust should review the current approach to accessing training programmes and ensure some method of evaluation of competency and achievement of learning goals and post training supervision.

The clinical risk training should link to the DoH best practice guidance for risk (2007) and NPSA suicide prevention guidance (2009) and the content of the training should follow the structures and processes outlined in the clinical risk policy, and reflect the clinical pathway through the service. The benefits of this training will only be realised if it relates directly to clinical practice and where classroom based training is reinforced by supervised practice and ongoing clinical supervision. In keeping with recent developments, consideration should be given to adopting a formulation-based approach supported by appropriate training. This should ensure a better understanding of the nature of the risk(s) presented while highlighting recent change in risk, protective factors, signature risk signs and lead to more appropriate risk management interventions and care plans (Lewis and Doyle, 2009).

Recommendation:

The Trust should consider adopting a formulation-based approach supported by relevant training.

East / West Divide

A significant number of staff reported on the different customs, traditions and practices, which have built up over a long period in the different organisations prior to the merger a few years ago. We understand there is a lingering resistance to accommodating practice from the other Service, which leads to inconsistency of approach. The West side feel they

are left out, are disadvantaged and have ideas imposed on them. The West are viewed as conservative, not pushing to change.

Service Users

We sought to meet with a group of service users, however only two were available. One was a young man, who was experiencing his second inpatient admission. He told us he had minimal concerns and was positive about the ward activities and links with his key worker, but would have liked to see his doctor more frequently.

The second was employed as a service link worker across various wards at St Clements. He had no concerns, apart from the heavily tattooed appearance of a member of staff, and he was very much looking forward to the new inpatient build and talked positively about the preparation for discharge arrangements. He attends weekly meetings on each ward and he believes this is a vehicle for service users to raise issues and get some action, thereby reducing the likelihood of complaints. He commented positively about staff attendance at these meetings, but regretted the perceived poor attendance of managers at these same meetings.

Child and Adolescent Mental Health Services (C.A.M.H.S)

The tight timescales of this review has prevented an in-depth appraisal of the CAMHS Services.

This is a matter of regret, as the cluster of homicides independent investigation highlighted a number of issues of concern.

We have taken into account the age and history of Mr J.R., the young man whose death on Southgate Ward triggered this review.

We also noted from a tragic SUI report, following the death of a young man with a diagnosis of Autistic Spectrum, concerns in respect of the transition from CAMHS to Adult Services. We were advised, that since the incident, protocols have been developed which focus on transition points, along with closer monitoring of 17 year olds, as they move towards their 18th birthday.

From our interviews, we also discerned a number of concerns specific to the CAMHS Service including:

- No inpatient beds – admissions to beds in other areas and the potential movement and distress of young people especially at night
- Different policies in the East and the West Divide, re care and treatment of 16 to 18 years of age. Designated beds on adult wards for very short periods, in line with national guidance needs to be developed
- Relationships with social care services were said to be not as robust as they might be

- Sometimes the service is criticised by Education Services re not sharing confidential information

We were told that:

- Sometimes consultants keep caseloads open too long
- Risk training is adult focussed
- Not enough energy given to medical leadership; no identified lead; others reluctant to support
- A lack of management of medical staff by service manager can cause frustrations and stress for the other members of the team. Medical staff appear to work autonomously
- Currently a consultant psychiatrist is away from duty receiving knowledge / practice enhancement

Of note, we did not have the opportunity to further check the validity of these concerns.

We suggest that these concerns be examined more closely.

The transition from adolescence to adulthood is a crucial stage of social, personal and emotional development. It coincides with the emergence of personality disorders, particularly the severe end of the spectrum of affective disorders, anxiety and eating disorders, psychoses and obsessive compulsive disorders.

Also, co-morbid substance misuse is common amongst young people, which adds to the complexity of presentation and treatment and care needs.

Nationally, there has been long standing concern about young people with mental health problems who may fall between CAMHS and Adult Services.

Recommendation:

We recommend that the Trust and PCT collaborate in reviewing communication and cooperation and evaluating the current position to identify any gaps in provision with a specific focus on the Adolescent / Adult interface, and ensure appropriate guidance, agreements and resources are in place for effective transition planning, and care programmes which result in effective engagement of young people and their families in mental health and social care services.

To assist this process we urge those involved to take account of the Royal College of Psychiatrists good practice guidance entitled, 'Working at the CAMHS / Adult Interface: Good Practice Guidance of the Provision of Psychiatric Services to Adolescent / Young Adults. A joint paper from the interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists, May 2008. Editor: Lamb C.

NURSING LEADERSHIP

Nursing leadership at ward and service levels is vital to the delivery of safe high quality care to patients.

Nurses leaders should have the capacity, time, resources and the authority to coordinate and develop patient care, in particular with others in the MDT and with patients and their families.

For various reasons, it seems to us that this has not been a priority within the Trust. We have made comparisons with other similar sized mental health trusts, who have in place a number of Nurse Consultants, Nurse Specialists and Advanced Practitioners, and have developed and supported the role of qualified and accredited nurse prescribers. These roles bring about a greater focus on expert care and practice, enhancing the patient experience, the use of evidence, provide supervision and support to less experienced staff, and ensure a focus on the effectiveness of care interventions. In the context of this review, developing nurse leadership is even more important.

It would ensure professional challenge and influence of senior medical consultants, who may have adopted narrow professional interest, and bring out the best in medical staff and help them use their skills to the optimum benefit of patients and their families. It would result in service innovation and practice development and alternative models of intervention. It would also help with recruitment problems. In other Trusts nurse leaders have ensured a strong focus on evidence based practice of health care quality and benchmarking of standards. They regularly contribute to quality accounts of patient care.

Recommendation:

We recommend that the Trust reviews the roles, responsibilities and accountabilities of nurse leaders at all levels with a view to strengthening their capacity to make contributions to good standards of clinical care delivery and influencing the care and therapeutic environment and decisions within the organisation, which impact on safe care. The review and subsequent actions should also focus on knowledge and skills development and the provision of authority to make decisions which impact on patient care and safety.

STRENGTHS AND POSITIVE PRACTICE

The Terms of Reference required the panel to identify the service strengths.

Set out below in no particular priority order and in headline form are a range of positives.

- The vigorous response to our early recommendations to offset remaining ligatures by focusing on relational and procedural safety
- The attitude of those we interviewed which was open, professional, honest and determined to take forward any lessons and actions from this review. (It is worthy of mention that elsewhere on occasions when conducting reviews of this nature, panel members may encounter suspicion and resentment)

- Generally staff report that they were given support by their line manager, immediately after an SUI. (Although we were made aware of one exception following a homicide incident)
- Contact with families following incidents appears to be embedded practice
- Positive attitude of Chief Executive and Director of Nursing despite disappointments re Foundation Trust Status
- Enthusiasm for productive ward initiative
- Weekly clinical supervision group facilitated by Psychologist to aid reflective practice in the Crisis and home treatment team (CT/HT) in the East Sector
- Leadership of CT/HT in the East and the co location and integration and collaborative model of working
- GP praised compassion and link with Consultant Psychiatrist in the East Community Team.
- Learning from experience, bi monthly workshops
- Experienced, committed and professionally sound group of Modern Matrons
- Progression of new build - Acute Unit
- Many MDT working processes are said to have improved
- Improved integration between the Assertive Outreach Inpatient and Community Teams in the East
- The appointment of a Service User representative and role in raising issues and seeking improvements to patient satisfaction
- Input from Psychologist is valued by clinical team
- Revised MDT handover model on Southgate ward with use of SSORNA risk tool to aid systematic sharing of key information
- User/Carer action group Wedgewood Unit
- New Model of care introduced last October on the Wedgewood unit and open day with invited partners to discuss the initiative

- In the CJSMH service they have developed a comprehensive policy re patients who did not attend
- CAMHS use of the Common Assessment Framework
- A new transitions policy and protocol developed for monitoring 17 ½ year olds as a response to a recent SUI
- The development of the DATIX reporting system

CONCLUSIONS

Due to the urgency of need for the review and the time available, the scope and depth of the investigation was necessarily constrained by the time available.

Nevertheless, we believe the five days spent in the Trust interviewing significant people, visiting the wards, the extensive reading and our subsequent follow-up with telephone conversations, correspondence and responses to questions has enabled a thorough review and identification of issues.

We have been impressed by the openness and readiness of the Trust Directors to contribute to the review and their positive reactions to feedback during the review. We hope that the Mental Health Trust and the N.H.S.Suffolk find the analysis provided in our report cogent and credible. We hope it will be of value as an agenda for action in supporting safer care.

We have identified a number of serious concerns, in particular medical leadership, management, practice, accountabilities and medical involvement in clinical governance and audit. Our findings on these matters affirm what had previously been highlighted in the report of the independent investigation into the cluster of homicides (The Shelton Report), which was completed in December 2009.

We consider that Dr Lowe understood what was needed and had set about tackling the concerns in an insightful manner. Regrettably, he was undermined by a small number of consultant colleagues, who were resistive to the positive and necessary change and improvements he was appointed to bring about.

We have also identified concerns regarding the care, support and treatment of individuals assessed as having personality disorders with associated emotional disturbance and social and relationship problems, who present with challenging behaviours.

We have pointed out key areas for the Trust to address in ensuring a safe, high quality in-patient environment. The report highlights the physical, relational and procedural areas for development, and we acknowledge the swift and purposeful response by the Trust to our notification of areas of concern following our initial visits.

We believe, it is necessary to have a refreshed and sustained focus on patient safety, risk assessments and management and effective multidisciplinary working, particularly in the West Sector of the Service. A renewed focus on the East / West culture and practice split would bring about positive change.

We urge the Trust to take forward the recommendation of establishing a Trust wide suicide prevention steering group and re-establish a more vigorous acute care forum. Also, to continue with the learning from experience safety workshops and other service improvements and professional training and development initiatives. We consider the clinical governance SUI investigation process and systems are generally sound and improving, but greater attention and energy is required in ensuring lessons learnt are disseminated and implemented in a timely manner.

In addition to practice and systems, we have been careful to take account of the human factors, such as values, motivation, conscientiousness, openness, positive attitudes and a desire to improve the care service users and their families receive. These are all critical ingredients in delivering high quality and safer services and dealing with pressures in the workplace.

We believe, we have discerned much evidence of these characteristics and qualities in many of the people we have met, albeit some of the tensions and problems we have commented on have impacted on their optimism, resilience and resolve.

We urge the Trust and the N.H.S.S. to preserve and build on these positive factors and further support and encourage staff to realise their potential, wellbeing, professional development and support clinical leadership in all of the professions.

We have also concluded that there are some geographical concerns. We have noted that many of the staff have worked in the service for a long time. This brings many advantages of continuity, commitment to service and locality along with a specific local awareness.

However, it can also bring some disadvantages associated with a potential for insularity, acceptance, complacency and a lack of drive to modernise and change. In the best organisations a mixture of both a constant and consistent workforce, combined with dynamic new staff, who could bring fresh ideas and practice initiatives from other places, and challenge the status quo. This is not an easy problem to overcome, but we consider it sufficiently important to spotlight and encourage initiatives to recruit experienced others, who bring extra value to build on what currently exists.

We commend the recommendations to you and hope they will provide additional benefit to build on the many positive developments underway.

We anticipate substantial change ahead, the proposed merger; changes arising from the coalition government's proposals for the NHS; a new Mental Health and Public Health Policy and in the spring, a new National Suicide Prevention Strategy.

We strongly urge those in key positions to influence decisions; to take account of an important finding in this report, namely, to avoid overwhelming pressurised 'frontline' clinical staff with an excessive amount of initiatives; to listen to their concerns and empower them to raise safety issues earlier and also, to sequence change in a coherent order with achievable deadlines. It is vital that the essential goals of the service of ensuring a safe, quality care and treatment and maintaining the health and wellbeing of staff is not obscured by organisational aims and imperatives.

Finally, whilst we have highlighted the serious concerns earlier, it is critically important to keep a sense of perspective and proportion. To assist this, we have also identified a range of positives and strengths within the organisation.

The nature of Mental Health Services is complex, unpredictable and subject to a range of variances. We consider that the Trust has many positive elements in place, and if the prime issues of concern are addressed, we believe the Service has the potential to conform to contemporary positive mental health service provision .

RECOMMENDATIONS

We give below recommendations to achieve the necessary improvements. For ease of reading and comprehensive understanding and completeness, we have included the recommendations sent to the Trust on the 23rd December 2010.

Recommendations, following our visit to the Wedgewood Unit on the 22nd December 2010:

1. SHORT TERM ACTION

- To have daily inputs to the wards from the Consultant Psychiatrist or their deputy to oversee the review of the risk plans and any emerging patient safety concerns.
- To develop more systematic shift handovers that includes medical staff, and covers the full name, diagnosis, M.H.A. status, observation level, leave status, presenting risks and signature risk signs, current treatment plans and current mental state.
- To increase the ratio of staff to service user by the addition of more staff and/ or reduced beds.
- To have more frequent checks on the whereabouts of service users
- To conduct the NPSA '*Ward Managers Checklist*' as soon as possible and at least monthly thereafter
- To proactively improve relational safety through daily 1:1 sessions between service users and nursing staff, which are clearly structured and documented in the clinical notes and contribute to care planning and effective clinical management. We suggest the 1:1 time could occur in various forms, for example, short conversations, recreational activity, social interventions, escorted trips, all aimed at engagement and communication, and gives the additional opportunity for observation, assessment, motivation and the building of therapeutic and trusting relationships. The activity and time involved should be tailored to individual needs and presenting problems
- To ensure all service users have a personal risk formulation in addition to risk rating identification and implementation of a relapse signature risk signs checklist, to be used to monitor early signs of risk. This should inform clinical judgements and relapse signature risk signs should always be considered prior to leave or discharge
- To establish a reflective practice group, peer reviews and co-working with service users who present with difficult and challenging behaviours

2. MEDIUM AND LONGER TERM ACTION

- To revisit the Trust policy for individual and personal property searches for in-patients to ensure regular monitoring of service users belongings. In our communication with the Trust we urged that this includes a policy for mobile

'phones, as the use of charger cords have been used to self harm elsewhere. We also advised of the potential problems of service users reacting to conflict or negative calls or text messages

- A senior team including a Senior Manager and a Ward Manager to complete the NPSA **General Audit Tool**. We believe this will provide a comprehensive measurable view of the Trusts performance against best practice standards for suicide prevention, which should lead to the development of an action plan to address any concerns
- The audit should coincide with an overall suicide prevention environmental survey. All internal and external areas, materials, premises, fixtures, fittings and equipment that may increase risk of self harm should be identified and risk assessed. This should involve a repeat of a ligature survey and planned ligature risk assessment, with a view to ensuring that all ligature points are removed, covered up or managed, with bedrooms and other unsupervised areas being a priority.
- We appreciate this will bring many financial and organisational challenges however, the executive group will need to discuss ligature issues in a strategic and systematic way. They will need to make sure their discussions are informed by regular audits and stock takes, identifying the most serious and current risks ensuring they are then aligned to the estates strategy.
- The Trust should develop a suicide prevention steering group aimed at developing a Trust wide action plan to minimise the rate of attempted and actual suicide. This group should have clear terms of reference and have a membership that includes a Trust Executive Director as Chair; representatives from Governance and from all clinical disciplines, Senior Managers and a Senior Manager from Estates / Facilities. Consideration should also be given to inviting external persons to attend, who may be able to provide impartial and alternative perspectives
- Increased frequency and monitoring of suicide prevention and training, that includes consideration of real life case examples followed by supervised practice to ensure learning outcomes are achieved
- To develop a Trust-wide personality disorder policy
- Review the operational policy of the CRHT to ensure compliance with policy implementation guidance and current best practice

3. MEDICAL STAFF

- To undertake a review of medical leadership and management. This should lead to appropriate structures to support professional management of all doctors, and to support revalidation. The medical hierarchy should have a significant role, if not leadership, for clinical standards and governance. This would be in line with requirements for medical revalidation.

- Clear and appropriate job descriptions for all consultants identifying their involvement as senior clinicians in all aspects of the Trust's functions e.g. clinical governance and service development.
- Clear job plans, in line with national guidance, identifying appropriate time allocations to support 2 above. The job planning process to be significantly modernised, and identified separately from appraisal/revalidation. Consultant job planning should involve a senior manager, with resource allocation responsibilities, introducing challenge and rigour. All job plans should aim to be compliant with EWTD, and support Trust strategic objectives. All consultants should be fully accountable and demonstrate the highest standards of probity and good medical practice.
- Modernisation of the work force, including the development of Advanced Practitioners and non medical prescribers to support consultants following withdrawal of traditional junior doctor support (through EWTD and training). These developments to be undertaken in tandem with consultant job plan review to identify where they are most needed. Consultants should not be expected to act as 'sweepers', absorbing all work not done by others.
- To develop agreed terms of reference for the Medical Advisory Group. If this is to have a formal role in management of the Trust, then it needs to be appropriately accountable, and tied into Trust processes. An alternate route would be for the MAG to seek advice from the BMA, which provides a model constitution for Medical Staff Committees (MSC). In these circumstances the Local Negotiating Committee (LNC), is a formal sub-committee of the MSC/MAG, which the BMA industrial liaison officer attends. In these circumstances the role and function of the MSC is much clearer, canvassing and representing consultant views and interests through the joint meetings between the staff side and management team at the LNC.
- Develop processes to 'talent spot' and support succession planning in medical management. This should include nurturing young talent who have an interest in or aptitude for management, through training and clearly identified time in their job plans.

4. INFORMATION AND COMMUNICATION SYSTEMS

- There needs to be a records strategy to move to a single (electronic) patient record. Continuing to run dual record systems is an unacceptable risk. This would include a date when paper records would be withdrawn

5. RECRUITMENT AND RETENTION

- The Trust should take note of the concerns expressed, explore in more detailed issues and develop a more effective approach to the recruitment of good calibre staff.

6. PERSONALITY DISORDER

- We recommend that the PCT and Trust take the lead in developing a broad strategy involving Housing, Social Services, A/E, The Criminal Justice System, the Voluntary Sector and Primary Care representatives. Those involved should review the clinical management of people who present with a diagnosis of personality disorder and associated challenging behaviours, and take into account the problems we have highlighted.

7. CLINICAL SUPERVISION

- We recommend that the Trust should review the clinical and managerial supervision arrangements and ensure they are embedded into practice.

8. COMMUNICATION SYSTEMS

- The Trust should develop a Trust wide communication strategy, which should be regularly monitored.

9. ACUTE CARE FORUMS

- We recommend the Trust re-launches the ACF and ensures there are refreshed Terms of Reference, objectives and membership.

10. RISK ASSESSMENT AND MANAGEMENT

The Service should commission a task and finish working group with representatives from all disciplines to review the current clinical risk assessment and management policies and procedures, with a view to continue with FACE or explore an established and / or fit- for - purpose guideline or tool, to be introduced as an alternative.

11. TRAINING AND NEEDS ANALYSIS

- The Trust should review its approach to an annual training needs analysis to ensure future risk training is tailored to meet different needs of all levels and experiences of staff.

12. ACCESS TO TRAINING

- The Trust should review the current approach to accessing training programmes and ensure some method of evaluation of competency and achievement of learning goals and post training supervision.

13. FORMULATION BASED APPROACH

- The Trust should consider adopting a formulation based approach supported by relevant training.

14. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES.(C.A.M.H.S.)

- We recommend that the Trust and PCT collaborate in reviewing communication and cooperation and evaluating the current position to identify any gaps in provision with a specific focus on the Adolescent / Adult and interface, and ensure appropriate guidance, agreements and resources are in place for effective transition planning, and care programmes which result in effective engagement of young people and their families in mental health and social care services.

15. NURSE LEADERSHIP

- We recommend that the Trust reviews the roles, responsibilities and accountabilities of nurse leaders at all levels, with a view to strengthening their capacity to make contributions to good standards of clinical care delivery, and to influence the care and therapeutic environment and the decisions within the organisation, which impact on safe care.

The review and subsequent actions should also focus on knowledge skills development and the provision of authority to make decisions which impact on patient care and safety.

16. EVALUATION OF PROGRESS

We recommend that NHSS and SMHPT jointly evaluate the effectiveness of the action plans arising from these recommendations in six months time.

Appendix 1

Literature Review

Preventing suicide and violence

National guidance has recently been published promoting best practice in preventing suicide (National Patient Safety Agency (NPSA), 2009) and managing risk generally (Department of Health, 2007). In addition, there is an emerging evidence base supporting good practice in enhancing the safety of service users in mental health services.

Effective suicide reduction

The National Service Framework (NSF) for Mental Health identified a reduction in suicides as a key objective (Department of Health 1999). The NSF recommended a multi dimensional approach to delivery of mental health services and steps to take to reduce suicide. It required an approach, which embraces prevention and intervention

Acute inpatient care has been a national focus of concern for some years. Watchdogs such as MIND and research organisations, such as the Sainsbury Centre for Mental Health (Garcia et al 2005), have repeatedly called for improvement in these services. Particular concerns have been around incidents of inpatient suicide, with the first 72 hours after admission and the first 48 hours after discharge being acknowledged as higher risk periods within the care pathway.

In 2005 the National Confidential Inquiry into Suicides and Homicides (NCISH) reported that inpatient suicides are thought to be preventable by clinicians in 31 per cent of cases, compared with 22 per cent for all other suicides.

Suicides within hospitals are also often felt by families and carers to be preventable. The South Essex Trust v Savage brings this into sharp focus. Of 122 cases of clinical negligence relating to suicide, 78 involved service users who were inpatients at the time of the event. The DOH Prevention of Suicide Strategy of eliminating ligatures and ensuring collapsible rails has been successful.

However, vigilance and continuous preventative personal care and environmental strategies must be at the forefront of all Trusts.

A multi-agency / disciplinary approach to assessment, incorporating health and social care and CJS professionals, the voluntary sector and family members is required.

Suicide is often associated with depression, but suicidal behaviour is a feature of a significant number of psychiatric diagnoses such as schizophrenia, bipolar disorder, borderline personality disorders and post-traumatic stress disorder. Gallop and Stamina (2003) highlight that everyone in the mental health care system should be considered at risk of self harm, and therefore training for clinical staff needs to promote understanding and

knowledge of risk assessment and skilled interventions to form therapeutic relationships and prevent suicides.

Therapeutic Relationships

The essential therapeutic relationship between staff and service users have been emphasised in policy statement.

The Mental Health Act Code of Practice (2006) talks about observation and engagement aimed at positively engaging with the service user. The Department of Health's Acute Care Policy Guidance for in-patient provision (2002), recommended that wards must be organised and structured to take full advantage of the time spent directly engaged with service users and carers. The National Patient Safety Agency (NPSA) (2006) states that staff must develop trusting therapeutic relationships with service users, in which service users who feel suicidal or wish to self harm, can talk openly about how they feel and develop strategies, together with staff to manage self harm feelings and behaviours.

There are skilled based training requirements when nurses are aiming at therapeutic engagement and supervision is essential. Thorough risk assessment and excellent documentation are also needed if observation levels are to be reduced. (Duffy 2004)

Staff Training

A systematic review of studies published from 1980 -1995 found that as a result of training, knowledge about suicide improved but there were less positive effects in terms of help-seeking, attitudes, and peer support (Pignone, et al. 2002). A later review of studies published from 1990-2002 also found that curriculum-based programs increase knowledge and improve attitudes to mental illness and suicide but found insufficient evidence for prevention of suicidal behaviour (Guo and Harstall 2002).

The Scottish Executive (2002) in response to the high levels of suicide experienced in Scotland developed a strategy – *Choose Life* the national strategy to prevent suicide in Scotland. As part of that strategy a meta-analysis looking into the effectiveness of different interventions to prevent suicide was carried out (McLean et al. 2008, and Leitner et al. 2007).

Additionally the Scottish Executive commissioned the Scottish Development Centre for Mental Health, in partnership with the University of Edinburgh (Research Unit in Health, Behaviour and Change and General Practice Section) and the University of Stirling (Department of Applied Social Science and Department of Nursing and Midwifery) to undertake a review of the literature on risk and protective factors for suicide and suicidal behaviour.

As a result of this work and in line with their strategy the Scottish Executive introduced a range of suicide training programmes including Skills Training on Risk Management (STORM). This is a training programme currently delivered internationally as well as in Scotland. STORM is a suicide prevention training programme aimed at frontline workers in health, social and criminal justice services.

Gask et al (2008) reports on a study evaluating the STORM training initiative in a Scottish region. In this paper the authors state that training for health workers has been widely advocated as a key route to suicide prevention, however, reports of evaluations are scarce in the literature. In previous research, the authors demonstrated that the STORM intervention results in acquisition of new skills and can be disseminated in a community setting. Gask et al propose that STORM training for the assessment and management of suicide risk is both feasible and acceptable in mental health trusts. However, they remain uncertain of its longer-term impact, and cite problems associated with the lack of engagement of senior staff in the enterprise and the absence of linked supervision and support from the organisational management to reinforce skill acquisition and development. They recommend that regular supervision linking STORM training to actual clinical experience would be the ideal.

Appleby et al (2000) evaluated the delivery of STORM training to 167 health professionals during a 6 month period. This included 96 primary care staff, 21 accident and emergency staff and 51 mental health staff. Satisfaction with training was high.

Training for staff in Hospital settings

In the study by Samuelsson (2002) attitudes of psychiatric nursing staff towards patients who had attempted suicide were examined before and after a training programme in suicide prevention. Findings suggest that staff enhanced their understanding and skills in assessment and suicide ideation and moved to a more positive attitude towards patients.

Observations in inpatient settings

The aim of observations is to prevent service users who may be suicidal, violent or vulnerable from harming themselves or others. The five year report of the National Confidential Inquiry into Avoidable Deaths by Suicide (2005) found that the number of suicides of service users in hospitals under one-to-one observation had increased as a proportion of all inpatient suicides. This must beg the question of the effectiveness of observations in practice.

Failure to observe has been found in Australia as the main cause of claims for negligence. In a survey of litigation claims against hospitals in Australia from 1972 to 1992, in which 20 cases claiming failure to prevent suicidal behaviour were identified, all but one case involved inpatients and failure to supervise was the leading basis of the claims. (Vincent et al 2001)

The National Service Framework for Mental Health's standard seven (1999) called for prevention of suicide in services for people with severe mental illness and better risk assessment and management. Policy-making bodies and researchers have disseminated proposals and guidelines (for example, SNMAC 1999) for observation of service users.

Intermittent observation regimes provide long gaps in observation and they are unsuitable for the care of high risk service users unless additional measures are taken, such as the observation of ward exits. Secondly, close observation must be strictly carried out. There should be no gaps in one-to-one observation; and if a

patient is to be observed every ten minutes, this time gap must be carefully adhered to (Appleby L et al 2001).

Need to Balance Surveillance with Therapeutic Engagement

The paternalistic duties of vigilance and risk assessment can actually oppose the skilled interventions and opportunities for therapeutic engagement that should be part of the planned and collaborative care of the acutely ill individual. The Standing Nursing and Midwifery Advisory Committee declared that:

“Observation is not simply a custodial activity. It is also an opportunity for the nurse to interact in a therapeutic way with the patient on a one-to-one basis.” (SNMAC, 1999)

One study found that many service users are not involved in the process of observation and therefore can find it frightening. Staff also reported finding observation stressful, boring, or even frightening (Duffy, 1995). Similarly, Whittington and McLaughlin (2000) found that 80% of the time nurses spend ‘doing’ constant observations but this task would actually be categorized as non-interactional. Some researchers doubt that special observation, undertaken as surveillance, is a necessary or helpful feature of working with those assessed as at risk (Stevenson & Cutcliffe, 2006).

Staff undertaking observation

In budgetary terms preventing suicide by means of intermittent and special observation has been found to be expensive: £90.1 million worth of resources are estimated as being used by acute adult in-patient wards in England (Bowers et al 2006). Staff shortages which may be a result of financial constraints will have an influence on observations and time for therapeutic engagement. Staff may also have not been recruited and vacancy rates for inpatient nurses remain high at 4.7% compared to 1.9% for community nurses; there is a concomitant reliance on agency staff which may lead to inconsistent and non-therapeutic care (Bowers et al 2006).

Service users may find being observed makes them feel safer but service users interviewed by Jones et al. (2000) stated that being observed by someone they did not know, such as bank staff, made them feel less safe. Non-therapeutic aspects of observation have been described by service users as observers’ lack of empathy, lack of recognition and failure to give information about constant observation, as well as a lack of privacy and feeling imprisoned (Jones 2000).

While research (Cutcliffe, 2002) shows that most observation for service users who are assessed as a suicidal risk is carried out by nursing assistants, students or bank staff, MacKay et al (2005) found that trained staff were mostly used to observe those risk assessed for violence or aggression. The processes used in these cases were described as caring and interactive. In practice though often the demands on RMN’s time in a busy acute ward from paperwork, meetings and organising tasks precludes opportunities for meaningful therapeutic engagement with service users as Bowles et al (2003) found:

“When the process of acute mental health care is dominated by the practice of formal observation, it may fail to meet service user needs and promote a negative environment for both patients and staff.”

On all inpatient settings, service users assessed to be at greatest risk of harming themselves or others are nursed on the highest level of observation, with service users never being left alone by nurses, and with the nurse within sight and often within ‘arm’s reach’ of the service user. However, the way that these levels are used, and how observation is conducted in general in the UK, varies considerably, with the use of different terminology, policies and practice (Jones 2004). Constant observation of inpatients with suicidal ideation seems to consist of two main aspects according to Vrale (2005):

“In the beginning, control is the most distinct aspect. As constant observation progresses, the relationship between the patient and the nurse develops into a therapeutic relation.”

Meaningful activity, intermittent observation as well as therapeutic engagement can lessen the risks of self-harm; Bowers et al (2006) found in their study of acute inpatient wards that:

“The variables that are associated with reduced moderate self-harm are having planned patient activities and intermittent observation”

This study found that increasing intermittent observations was one of the most effective ways of preventing a service user self-harm. However intermittent observation has been a practice that is controversial; for example, NHS Scotland’s guidance on observation (CRAG 2002) has eliminated the level of intermittent observations altogether.

In reality, clear protocols for observation levels, timings and changes may not be present or ignored because of day-to-day pressures on staff. The Department of Health's acute care guidance document (DOH 2002) notes the lack of:

“One-to-one contact with staff..... Risk is increased when policy and practice is not clear or sufficient”

Risk factors for in patient suicides

Certain risk factors have been identified for inpatient suicides which staff need to be continually aware of in ongoing risk assessment (King et al 2001). These are:

- Being admitted under the Mental Health Act, or after involvement with police,
- The presence of depressive symptoms and a history of deliberate self-harm
- Display of violence to property
- Going absent without leave.

Service user related factors are easily recorded, either as part of the standard admission procedure or in routine ward observations. Some factors arise less often, for example being admitted under the Mental Health Act and/or via the police. Violence to property and being AWOL are comparatively infrequent (King et al 2001).

Environment

Hanging is the main method of suicide for mental health service users whether in patients or community (Duffy 2009). Hanging may involve suspending the body from a high ligature point with or without the feet touching the ground but many deaths occur through Asphyxiation without suspension of the body and using a ligature below head height. It is almost impossible to eliminate all potential ligature points as a significant proportion of suicides are impulsive acts using the first means to hand. An obvious ligature point would then present a significant risk. The National Suicide Prevention Strategy for England (DOH, 2002) sets the standards that likely ligature points in mental health service in patient environments must be removed or covered.

Due to human ingenuity it is not possible for all ligature points to be addressed and a judgement has to be made about the likelihood of something being used as a ligature point and this must be done in a balanced way. Tools have been developed to help staff address the risk of hanging in a balanced, objective and systematic way (Duffy 2009). All clinical services should be required to carry out inpatient audits regularly and liaise with estates and facilities to ensure the removal of potential ligatures.

Violence risk assessment and management

Assessing and managing risk to others from users of mental health services is becoming increasingly relevant to the practice of mental health professionals. Although the link between mental disorder and risk to others is nothing new, in recent times there has been an increasing concern in the United Kingdom in relation to violent behaviour. Over the past two decades a relatively small, yet significant number of incidents involving people with mental illness have received considerable media attention (e.g. Ritchie et al, 1994; NHS London, 2006) and this has left a strong impression of the potential dangerousness to the public from individuals with various forms of mental disorder.

A recent report (National Confidential Inquiry, 2006) highlighted the fact that service users recently in contact with mental health services commit around 9% of all homicides in England and Wales. This translates to 52 per year and 30 by people diagnosed with schizophrenia and is a figure that has been constant for over 50 years (Taylor & Gunn, 1999). In addition it is likely that nearly one in five service users are violent within six months post-discharge (Doyle & Dolan, 2006). In in-patient settings violence by people with a mental disorder is a major cause for concern amongst service users (NICE, 2005). Findings like this fuel concern about perceived failures in provision of effective treatment and management and the overall competence of mental health services to prevent violent behaviours. This can result in increasing stigma and impede recovery and social inclusion for service users.

Violence and risk assessment

Risk assessment is an inexact science. Ultimately the decision on the level of risk is based on clinical judgement. As clinical decisions on risk are made at all stages of the clinical care process it is important that clinicians have a clear rationale for the structure underpinning their approach to risk assessment and management. There are a number of risk and protective factors that are important to consider when assessing the risk of violent behaviour.

A number of scales, tools and guidelines have also been developed to inform and structure clinical judgements. These should be viewed as decision support tools that will support clinical judgement rather than replace it. The use of any decision support tool will depend on the individual service priorities. Services will need to use tools that are based on sound scientific knowledge and are practically relevant and ensure they promote transparency and guide management interventions.

Managing violence

In order to effectively prevent and reduce the risk of violence safely and effectively, clinical interventions will need to be provided in accordance with certain principles (Byrt & Doyle, 2007 - see below). The approach to managing violence risk will depend on a number of factors. It is recommended that a structured professional judgement approach be used when assessing, formulating and managing risk (Department of Health, 2007) and interventions aimed at managing risk should be based on individual risk formulation that highlights the origin, development and maintenance of risk behaviour (Doyle & Dolan, 2007). A risk formulation should communicate the risk of violence in in-patient and community settings.

Recognition and prevention of violence risk

Managing the risk of violence and aggression should be part of the CPA process. Measures that are proactive and aim to prevent harm occurring include:

- Rapport building and development of therapeutic relationship between the clinical team and the Service User
- Regular one-to-one time between the Service User and Care Co-ordinator and other members of the nursing team.
- Systematic Risk Assessment where early warning signs for violence and aggression are identified and included in a proactive negotiated risk management plan.
- Assertive engagement and outreach approaches aimed at pre-empting deterioration.
- Advanced directives where care plans are negotiated and agreed between Service User and the Clinical Team that can be implemented should any violent or disturbed behaviour occur.
- De-escalation of emotional distress.
- Collaborative care planning with the Service User to identify need areas and priorities for action.
- Physical Health Care Assessments to ensure physical risk factors are identified and considered when implementing therapeutic risk management measures.
- A fulfilling & collaborative activities programme to meet the personal needs of the Service User.

Secondary interventions for continued management of violent behaviour

Secondary prevention approaches need to be implemented in response to and immediately following an incident of violent or disturbed behaviour and may include:

- Ongoing attempts at de-escalation

- Effective communication
- Implementing crisis interventions
- Physical restraint
- Implementing advanced directive care plans
- Isolation from other service users and intensive nursing
- Seclusion
- Rapid tranquillisation

Ongoing care and management to manage violence

Ongoing interventions to manage risk of violence must be part of the CPA approach and, wherever possible, be in collaboration with the Service User and the multidisciplinary team.

A care plan should guide interventions and include:

- Monitoring of early warning signs by the Service User and others, which should be linked to a staying well/relapse prevention plan.
- Treatment strategies to include bio-psycho-social interventions as indicated.
- Supervision aimed at maintaining regular contact between services and the Service User and avoiding vulnerable situations.
- Victim safety planning, to ensure contingencies are in place to prevent harm to known potential victims (e.g. partner, family member, other service user, children).
- Crisis interventions to be implemented in the event of a relapse or escalating risk of violent behaviour.

Ten principles for managing risk of violent behaviour

1. Valuing and respecting the Service User and his or her individuality, uniqueness, diversity and dignity.
2. Ensuring safety, minimising risk to the Service User, staff and others.
3. Ensuring that all interventions follow the code of professional conduct, legal guidance and organisational policies and procedures
4. Provide interventions that are based on the best evidence available
5. Ensuring that all interventions involve the least amount of restrictions necessary to ensure the safety and health of the Service User and others
6. Ensure non verbal and verbal communication conveys respect, and appreciation of the Service Users perspective, experience and feelings; this approach is likely to prevent or reduce the risk of violence rather than increase it
7. Providing systematic and holistic assessment of needs and risks that take account of the Service User's unique and varied needs and problems
8. Ensure Service User involvement, as far as is possible, in the assessment and management process
9. Ensure recognition of distress that may underlie or contribute to an increase in risk of violence
10. Provide interventions within a therapeutic framework to inform both short term and long-term interventions. Wherever possible, the therapeutic framework should be:
 - Acceptable to the Service User and their carers & incorporate their views, and
 - Based on best evidence and the experience of Service User, carers and professionals in relation to what works in practice, and

- Delivered by Clinicians who have regular and high quality clinical supervision, support and education.

(Taken from Byrt & Doyle, 2007)

Summary

The literature review emphasises the importance of the following factors to support suicide prevention, reduce risk of violence and enhance safety generally in mental health services:

- Recognition that all service users in the mental health system are at risk of self harm
- Training for staff in suicide and violence prevention as well as risk assessment and formulation.
- Clear observation policies.
- Established staffing levels with minimum use of agency or staff that are unfamiliar with the ward.
- Therapeutic engagement balanced with surveillance.
- Staff to receive regular clinical and managerial supervision.
- Maintenance of a safe environment and the removal of ligature points.
- Best use of the layout and structure of the wards to promote observation and staff engagement.
- Structured professional judgements are recommended.
- Multidisciplinary assessment, formulation and management are encouraged.
- Service user involvement in assessment, formulation and management.
- Proactive measures such as rapport building, developing therapeutic alliances and regular 1:1 time are crucial for preventing risk.
- Monitoring of signature risk signs may help in preventing risk to self and others.

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APPENDIX 2

IDEAS FOR DISSEMINATION, SHARED LEARNING AND IMPLEMENTATION

- Some positive practice from other Services is provided below for the Trust to consider.
- Accountability, expectation to discuss, share, engage, explain, not just passing on of information
- Regular briefings / monthly newsletters: short and snappy, sent to all clinical leaders
- Develop a culture of openness, reflection and learning
- Solution groups / work streams to be convened to focus on hot topics
- Formal feedback to Universities and those responsible for internal programme development
- Selective critical incident email measures – Red for alerting to areas of concern, Blue for lessons to learn
- Text messages to key senior clinical management staff to alert to critical incident
- Use service user stories / vignettes to heighten interest
- Feedback to service user / carer meetings
- Establish a website and promote local discussion groups on hot topics emerging from SUI's
- Clinical supervision and reflective practice group and individuals
- Develop a mindset and approach to analysis and learning from near misses
- Organise and publicise positive practice events to amplify what works well
- Establish peer review with structures, purpose and focus on a single issue or bundle
- Benchmark with other Trusts
- Regular review of and revision of policy and practice guidance
- Job rotation to encourage learning
- Use cards, crib sheets and screen savers to get priority messages over
- Appoint and develop champions and enthusiasts to take forward key topics
- Have an intensive focus on a small number of topics to ensure embedded
- Use video for analysis and discussion

- Use case studies, real or fictional, as training and get a panel to undertake a review, to see if their findings match those of the original panel

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