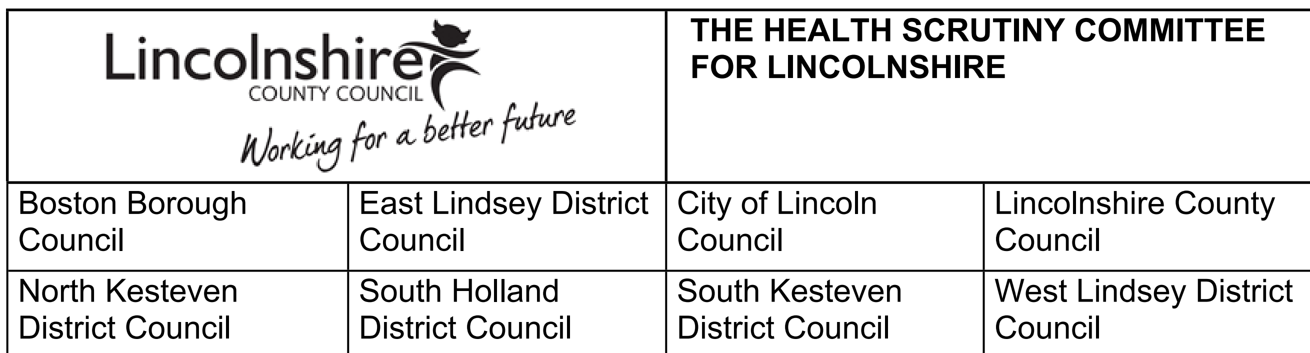

	THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE		
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Richard Wills, the Director Responsible for Democratic Services

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 May 2015**
Subject:	**Review of Suicides and Deliberate Self-Harm with Intent to Die within Lincolnshire Partnership NHS Foundation Trust**

Summary:

The *Review of Suicides and Deliberate Self-Harm with Intent to Die within Lincolnshire Partnership NHS Foundation Trust* was commissioned by the four Lincolnshire Clinical Commissioning Groups and Lincolnshire Partnership NHS Foundation Trust (LPFT).

The *Review*, which is attached at Appendix A, was considered by LPFT Board of Directors on 26 February 2015. The Board of Directors resolved 'to receive the report and to remit the scrutiny of the work to the Board's Quality Committee'.

The following representatives are attending from LPFT:

- John Brewin, Chief Executive
- Michelle Persaud, Director of Nursing and Quality

Actions Required:

(1) To seek assurance from Lincolnshire Partnership NHS Foundation Trust on how the Trust is responding to the *Review of Suicides and Deliberate Self-Harm with Intent to Die within Lincolnshire Partnership NHS Foundation Trust*.

(2) To determine whether the Committee would wish to seek further monitoring reports on the progress of the implementation of the recommendations in the *Review*.

1. Background

The *Review of Suicides and Deliberate Self-Harm with Intent to Die within Lincolnshire Partnership NHS Foundation Trust* was commissioned by the four Lincolnshire Clinical Commissioning Groups (CCGs) and Lincolnshire Partnership NHS Foundation Trust (LPFT). It was commissioned in response to a professional discussion relating to the incidence and potential underlying features of suicide and deliberate self-harm with intent to die of service users known to LPFT.

The *Review*, which is attached at Appendix A to this report, was undertaken by Professor Mandy Ashton and was completed on 30 November 2014. The *Review* considered a total of 88 serious incident reports, covering a period from January 2012 to June 2014, and included 73 user suicides (known to the service).

The *Review* makes a total of 21 recommendations in areas of risk management; record keeping; communication; procedure, policy and good practice; information technology; training; medicines management; safeguarding; staffing; commissioning; benchmarking; changed practice; and governance.

LPFT Board of Directors' Consideration

The *Review* was considered by LPFT Board of Directors on 26 February 2015. The LPFT Board of Directors was advised that the concerns specifically about risk assessment both in relation to quality and consistency across LPFT had been identified and acknowledged, in the main, through the Trust's Serious Incident process. A task and finish group had been commissioned prior to the *Review* being carried out, to develop a new risk assessment framework and training package. This had been piloted within LPFT with positive feedback. This work was positively acknowledged within the *Review*, which supported an agreement with the Clinical Commissioning Groups (CCGs) for the roll out of the training to form a local CQUIN [Commissioning for Quality and Innovation] for 2015/16. This will include the development of an audit tool to measure the quality impact.

The LPFT Board of Directors was further advised that in respect of record keeping, the *Review* had suggested that the exposure for LPFT, in light of the findings, was at three levels: corporate, clinical teams and individual. It concluded that LPFT should consider if there are expectation gaps within this continuum - and to formulate plans which proactively tackle actual or potential gaps. Where issues around poor communication were raised, they spanned all clinical members of staff within most LPFT services. The *Review* asked for consideration of improving effective two way communication across a diverse and geographically challenging environment.

The LPFT Board of Directors was also advised that IM&T issues underpinned some of the concerns raised around poor communication and record keeping, including the potential impact on clinical effectiveness.

The report to the LPFT Board of Directors stated that the *Review* identified a wide span of detail relating to failure to follow policy, procedure and good practice and recommended that an evaluation of the awareness and utilisation of policies and procedures should be completed and any gaps identified and addressed.

The report to the LPFT Board of Directors also identified that overarching issues of leadership and culture, specifically clinical leadership. The recommendation was that the Trust looked at strong systems of clinical audit, supervision, leadership development and Human Resource processes to improve understanding, skills and processes around clinical governance which, in turn would provide better and more robust Trust wide assurance.

The LPFT Board of Directors concluded by welcoming the Trust's initiative in commissioning the *Review*, the findings of which would provide a vehicle for positive improvements in the future. The LPFT Board of Directors accepted the findings of the *Review* and agreed that Board's Quality Committee would monitor the action plan and report to the Board of Directors; this would include the monitoring of the improvements in organisational culture. The Board of Directors resolved 'to receive the report and to remit the scrutiny of the work to the Board's Quality Committee'.

LPFT's Quality and Risk team are responding to the recommendations of the *Review* and have commenced the improvement work required. LPFT has developed a Service Improvement Action Plan.

CCG Governing Body Consideration

The *Review* was considered by the Lincolnshire East CCG Governing Body on 26 March 2015 and by the Lincolnshire West CCG Governing Body on 22 April 2015. In each case the Governing Bodies were advised of the action being taken by LPFT in response to the *Review*.

South West Lincolnshire CCG Governing Body and South Lincolnshire CCG Governing Body are due to consider the *Review*, together with the action being taken by LPFT, at their next meetings on 28 May and 29 May 2015 respectively.

The main vehicle for monitoring the implementation of LPFT's Service Improvement Action Plan by the CCGs is the LPFT Contract Quality Review Group, on which each CCG is represented.

2. Conclusion

The Health Scrutiny Committee is invited to seek assurance from Lincolnshire Partnership NHS Foundation Trust on how the Trust is responding to the *Review of Suicides and Deliberate Self-Harm with Intent to Die within Lincolnshire Partnership NHS Foundation Trust*.

The Committee is also invited to determine whether the Committee would wish to seek further monitoring reports on the progress of the implementation of the recommendations in the *Review*.

3. Consultation

This is not a consultation item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Review of Suicides and Deliberate Self-Harm with Intent to Die within Lincolnshire Partnership NHS Foundation Trust, by Professor Mandy Ashton MSC, BA (Hons), DPNS, RGN, OBE

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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