Review of suicides and deliberate self harm with intent to die within Lincolnshire Partnership Foundation Trust

Report commissioned by:

All Executive Nurse and Quality Leads, Lincolnshire Clinical Commissioning Groups, Lincolnshire

Michelle Persaud, Interim Director of Nursing and Quality, Lincolnshire Partnership Foundation Trust, Lincolnshire

Author:

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About Professor Mandy Ashton

Professor Mandy Ashton, worked in the NHS for 31 years, starting her career as a nurse at the Leicester Royal Infirmary. She has a first class BA (Hons) in Health Studies and an MSc in Managing Change. Mandy is a qualified performance coach.

During the first 10 years of her career, Professor Ashton progressed to a ward sister and then to assistant director of nursing in Leicester. She worked in the Trent Region, most notably in South Yorkshire and Lincolnshire as assistant director of performance. Mandy worked as a nurse researcher and nurse leader in Labrador and Uganda with the Grenfell and Mildmay charities respectively during this time.

She has worked as director of nursing and quality at Leicester General Hospital NHS Trust, director of nursing and research for NHS Leicester City West and director of quality and deputy chief executive for NHS Leicester City.

Professor Ashton has also been involved in the discussion of healthcare issues at a national level. In 1997 she contributed to the Government's programme "A First Class Service" which set out plans for the modernisation of the NHS and the introduction of the concept of clinical governance.

She has been an adviser to the Department of Health on NHS commissioning, and regularly invited to speak on a national level on matters ranging from leadership, clinical governance, risk and safeguarding children, young people and vulnerable adults.

The recipient of many awards, most notably an OBE for services to healthcare and nursing, Professor Ashton continued to immerse herself in the healthcare arena during her appointment in 2011 as Pro Vice Chancellor (Transformation) and Dean for the Faculty and Health and Life Sciences at De Montfort University, Leicester. A ground breaking partnership with MacMillan Cancer Support was established as an innovative project which resulted in students volunteering for the charity whilst studying. She was appointed as a commissioner for the Leicester Child Poverty Commission in 2011 and as a commissioner on the Bishop's Commission on Poverty in Leicester and Leicestershire in 2014.

Professor Ashton became an independent consultant in September 2014 and is the Managing Director of Mandy Ashton Consultants Ltd., based in south Leicestershire. Mandy is currently most notably the Project Director at the Royal College of Nursing leading the mentorship and practice based learning project for the UK.

Executive summary

This report was jointly commissioned by the Executive Nurse at South West Lincolnshire CCG (the Commissioner) and the Interim Director of Nursing and Quality at Lincolnshire Partnership Foundation Trust (the FT). This was 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 services users known to the FT. It was within this context that a short commission (5 days) was placed with jointly agreed terms of reference:

1. To identify the themes and trends from serious incident reports (suicides and deliberate self harm with intent to die) between January 2012 to June 2014);
2. To benchmark the level of inpatient and outpatient suicides and deliberate self harm with intent to die against national data and statistical neighbours;
3. To ascertain whether the provider has reliable and valid screening instruments in use to assess suicide risk;
4. To identify links to safeguarding;
5. To determine whether lessons learnt through RCAs have led to changes in practice;
6. To prepare a short report highlighting important issues and possible measures for strengthening management of risk.

A total of 88 serious incident reports (reports) were scrutinised for the review. These were paper copies provided by the Federated Clinical Risk and Compliance Team. Eight reports were excluded as subject matter was not within the parameters of the review. Seven related to service users with deliberate self harm with intent to die, four related to deaths in custody, 73 were user suicides (known to the service). These covered the time period as per the terms of reference. The source of the data was STEIS.

The recommendations within the report give a clear indication of improvements required within the FT and commissioning body. As such the report is not a stand alone product, but the findings and recommendations require consideration and methodical process around next steps and timescales for action. The length of commission was short (5 days) and based upon evidential fact finding: improvement and response needs to be strategically planned.

The complex nature of illness and its consequences is difficult to express within a formal report. This review is a sanguine reminder of the difficult lives and experiences of service users (and their carers), which has often resulted in tragic outcomes. Excellent practice was observed in parts of the review and a section which documents this is included accordingly. It is important that the report is read in this context.

1. Themes identified in the review

1.1. The most frequently occurring theme was **poor risk assessment** and **associated risk contingency**. In descending frequency of occurrence other themes were: **poor clinical record keeping, communication, failure to follow procedure/ policies, training deficits, IT system issues, medicines management, safeguarding, staffing and lastly commissioning issues.**

1.2. There are three overarching themes identified which encompass all themes - **leadership, governance and culture** within the organisation. Discussion relating to these themes is interwoven throughout the report.

1.3. The following abbreviations have been used throughout this section: SR (Suicide Reports), DSH (Deliberate Self Harm with intent to die), DIC (Death In Custody).

2. Risk assessment
Theme occurrence in reports reviewed: SR: 45%, DSH: 28%, DIC: 0%

2.1. This was a significant, almost overwhelming theme: risk assessment processes were not completed or updated consistently and methodically and risk contingency plans were often not in place. This is a fundamental necessity within the high risk service provision of this client group. It is a basic building block for appropriate care planning and the delivery of optimum care.

2.2. It was quite concerning to see such a level of non conformity over a prolonged period of time. This theme was constant throughout all the period reviewed and was present in all geographical areas and services within the FT. There was no evidence available within the documents reviewed to suggest any improvement during the past two and a half years. This would **suggest** that there could be cultural issues in terms of not conforming, or knowledge gaps, or that the screening tools being used are inadequate.

2.3. I have been informed that a new screening tool has been piloted within the FT during the last six months. I have been informed that this was in response to the acknowledged overwhelming theme of poor risk assessments within clinical practice. This was pleasing to see that actions were starting to be taken to improve practice.

2.4. I understand that plans are proposed for the rollout of this new screening tool across the FT with the support of a CQUIN from commissioners. I would urge that the rollout is

speedily and methodically rolled out across the FT to start the process of addressing screening deficits.

2.5. However, a new screening tool will not tackle cultural issues if they exist within the FT nor would it bridge learning and educational gaps. I would suggest further consideration and discussion of culture should be useful at Board level. It may be helpful to consider overall staff engagement within the FT and consider a suite of diagnostics which may give insight into the level of staff engagement at present. Consideration should also be given to actual and perceived knowledge gaps in clinical staff.

2.6. Leadership is a important component within clinical teams. An appropriate questioning of a clinical leadership culture which has accepted this repetitive inadequate practice (consciously or not) needs to be considered. Strong FT wide systems of clinical audit, clinical supervision and leadership development at all levels of the clinical community would be ways in which cultural barriers and poor clinical practice may be addressed. I would suggest that these systems are reviewed, refreshed and relaunched to give assurance that the clinical governance structures are in place do support and govern clinical practice in a regenerated way.

2.7. I was informed that 73% of staff have received risk management training in the FT. I have not reviewed the training package and its relevance to this review.

2.8. Recommendations:

2.8.1. Consideration should be given at Board level to the culture of the FT in light of this finding and consider the level of engagement of staff with the FT;

2.8.2. Subject to the pilot results of the new screening tool being positive, the tool should be systematically rolled out across the FT with appropriate training and development to support its introduction;

2.8.3. Thought should be given to an effectiveness audit of the new screening tool in six months time and amended accordingly;

2.8.4. The risk management training of clinical staff should be reviewed to ensure the content and format of learning meets the requirements of the service;

2.8.5. Consideration should be given to bespoke programmes of development which address learning needs associated with this service user group;

2.8.6. There is a mandatory requirement for all staff to undergo risk management training and a target date for 100% compliance should be agreed at the Trust Board with progress to target being monitored three monthly;

2.8.7. On a three yearly basis there should be mandatory risk management training (up-dates) for all staff;

2.8.8. There should be consideration by the FT Board of the effectiveness of current clinical audit, clinical supervision and associated clinical governance systems and processes.

3. Record keeping
Theme occurrence in reports reviewed: SR: 37%, DSH: 28%, DIC: 0%

3.1. Poor record keeping was a significant issue for the FT within the parameters of this report. It was prevalent in all geographical areas and included: lack of contemporaneous record keeping, no records completed on assessment, lack of handover records between staff members when service users were transitioning to other parts of the service, or were being discharged. A failure to record service user involvement in their care was also noted. These omissions were found in every part of the service user care pathway: it is an issue requiring serious consideration by the FT Board. On six occasions poor record keeping had a material effect on CPA processes.

3.2. The exposure for the FT in light of the findings is at three levels: corporate, clinical teams and individual. I would point to a continuum of caring (in which record keeping is essential) and the contextual culture in which this takes place with a) the individual demonstrating behaviours and utilising their authority to act as a professional, b) the leaders of clinical teams executing their duty to assure best practice within their teams and c) corporate clinical governance structures and processes providing a firm and explicit framework to support optimal clinical performance. It may be helpful to consider at Board level if there are expectation gaps within this continuum - and to formulate plans which proactively tackle actual or potential gaps.

3.3. Recommendations

3.3.1. The Board should consider whether cultural values and clinical leadership behaviours are congruent with expectations of optimal clinical performance and make plans to address any gaps identified;

3.3.2. Clinical leaders should role model behaviours and actions required in relation to record keeping with clear expectations to all staff relating to record keeping standards;

3.3.3. Policies relating to record keeping should be reviewed and reissued to staff within the FT;

3.3.4. A record keeping training audit should be carried out across the Trust, and appropriate training and education put in place to address gaps identified;

3.3.5. Clinical audit of record keeping as a rolling audit within the Trust must remain a priority: existing programmes of record keeping audits should be reviewed and results should be published three monthly across the FT.

4. Communication

Theme occurrence in reports reviewed: SR: 35%, DSH: 28%: DIC: 100%

4.1. There were high levels of evidence of poor communication between team members in all areas of the FT which fell into the parameters of this review: in patient, community teams, specialist services (DART) CAMHS, Crisis and IAPT services. This spanned all clinical members of staff and in one case, administrative staff.

4.2. One service user did not have a MDT review for 11.5 months due to poor communication between staff. One service user did not have a translator and was unable to communicate with staff: his sister expressed her fears concerning her brother, but his previous psychiatric history was ignored. A young person had services withdrawn for no identifiable reason within the notes due to court proceedings, once court proceedings had completed, services were not resumed. There are many examples from which learning needs to be taken and improvements made.

4.3. There was evidence of poor communication with and between external partners: prison services, Lincoln A and E, Boston A and E, G.P.s, Social services. On one occasion a FT staff member did not contact a GP concerning the transfer of a vulnerable service user into their area and care. Prison services were unaware of Saturday clinics available for service users to be referred into, consequently a service user was not referred in a timely fashion. Communication with safeguarding concerns was highlighted and will be addressed within the safeguarding section.

4.4 Recommendations

4.4.1. Consideration should be given at Board level to the culture of the FT in light of these findings within this theme and steps to address cultural change considered corporately;

4.4.2. Consideration of the effectiveness of clinical audit, clinical supervision, and clinical leadership development should be given at Board level;

4.4.3. Consideration of communicating effectively as a two way process with a diverse and geographically challenging environment should be given: specialist advice should be sought.

5. Procedure/ Policy / Good Practice: failure to follow
Theme occurrence in reports reviewed: SR: 30%, DSH: 14%, DIC: 0%

5.1. It was clear from the reports that staff had not, at times, complied with guidelines, procedures or policies. The span of detail relating to such occurrences is wide: for example, staff not being aware of dual diagnosis guidelines, not using safeguarding referral systems in accordance with safeguarding policy, non compliance with the medicines management policy, the search policy not used. Out patient appointments were not made for patients being discharged from in patient settings, A and E failure to refer to CMHT according to guidelines. Again there are many examples from which learning should take place.

5.2. The evidence would suggest that some staff within the FT are not utilising Trust policies, procedures and best practice, and within these report findings, this was a significant factor.

5.3. Recommendations

5.3.1. An evaluation of the awareness and utilisation of procedures and policies should be completed with consideration of methodologies to promote their presence, appropriateness/ relevance and utilisation;

5.3.2. Actions should be implemented to address gaps found within the evaluation;

5.3.3. FT Board consideration should be given to HR implications when there is a failure to act according to FT policy/ published procedures.

6. Information technology

Theme occurrence in reports reviewed: SR: 9%, DSH: 0%, DIC: 0%

6.1. This theme emerged in 2013 reports. I am not aware of the stages of IT development in the Trust, however the pattern is more prevalent in 2013; the theme is not present in 2014 reports and I am not able to conclude as to the reason for this.

6.2. System incompatibility was a clear issue: SystemOne, Silverlink and Bomic being named as three systems which are a) not compatible with each other, and b) various sections of the workforce do not have access e.g. DART cannot access the silver link system. These systems have powerful capacity in terms of sharing information, communicating risk, medication changes and other changes to care and risk management. They are potentially an extensive communication tool, which if one part is not connected with another, applies a supra level of complexity, ineffectiveness and risk.

6.3. This theme was linked with inter professional communication and an inability to share and integrate records.

6.4. Recommendation

6.4.1. There is a critical appraisal of IT systems compatibility within the FT which may affect clinical information sharing; actions are taken to address gaps identified.

7. Training

Theme occurrence in reports reviewed: SR: 7%, DSH: 14%, DIC: 0%

7.1. In one report there was evidence that new starters within the Trust had not received training to use an IT system fundamental to their roles (SystemOne).

7.2. There was evidence in one environment that a ligature audit was completed and remedial action taken in response to a DSH incident, within one year (in the same environment) there was a further DSH with an alternative ligature point being used. Although the numbers are small (2) both DSH events related to Ash Villa.

7.3. Recommendation

7.3.1. An IT systems training needs assessment should be progressed within the FT and appropriate actions are taken to address gaps;

7.3.2. Specific attention is drawn to the review of training for staff who complete ligature audits at ward level.

8. Medicines management
Theme occurrence in reports reviewed: SR: 7%, DSH: 0%, DIC: 0%

8.1. Although the total number included in this theme were small, I believe they were quite significant in their potential impact. Although one service user was in receipt of medication above the BNF advised dosage, there was no monitoring of this service user. A young person had administered a relatively high dosage of a drug, but at no time was there a conversation with a pharmacist or medic concerning this behaviour: it appeared to be normalised. Poor medication management is the underlying theme within this category.

8.2. Recommendation

8.2.1. A multi disciplinary approach should be used to review procedural matters of medicines management and associated clinical communication channels. Pharmacy professionals should be included at every point of this review.

9. Safeguarding
Theme occurrence in reports reviewed: SR: 7%, DSH: 0%, DIC: 0%

9.1. There was an underlying theme of staff not “Thinking Family”. Where there is domestic violence, drug and alcohol misuse, unpredictable behaviour of adults in the family, then staff must be mindful of the safety and well being of any children and young people within this setting. Where this occurs there should be referral in accordance with the FT safeguarding policy and the Lincolnshire wide safeguarding policy. These are clearly available on the FT website.

9.2. There is also a duty to follow up any referrals made should staff remain concerned about a situation: a referral should not be seen as a way of passing a problem on. Ongoing communication between different statutory services and professionals is a fundamental part of safeguarding activity: it is a minimal expectation.

9.3. The concept of vulnerability must also be at the forefront of professionals’ thinking and consequent actions. On occasion a safeguarding referral according to intercollegiate working guidance may not be appropriate, however should the professional believe there is a level of vulnerability and therefore risk, this should be documented and care planned appropriately. An example of this was a young adult who had spent the majority of their life in care: it was concluded that this was a fundamental feature which should have been con-

sidered within the risk screening process. It would have given a different profile and may have resulted in a different management plan. The complexity of lives and the building blocks of this complexity at an individual level is of vital consideration and requires further thought and discussion within the FT.

9.4. Recommendation

9.4.1. Safeguarding policy and procedures should become embedded within the FT: a structured methodical plan for training and development for staff should be agreed at Board level with ambitious timescales for its implementation and evaluation;

9.4.2. Safeguarding champions should be throughout the FT, trained as facilitators and educators for staff to contact for advice;

9.4.3. Progress with the above should be monitored at three months and six months with evaluation of improvements within 12 months.

10. Staffing

Theme occurrence in reports reviewed: SR: 3%, DSH: 0%, DIC: 0%

10.1. Specifically this referred to lack of supervision for staff in the Wolds, and a lack of psychology support in the Grantham area.

11. Commissioning

Theme occurrence in reports reviewed: SR: 2.7%, DSH: 0%, DIC: 0%

11.1. It was clear from two reports that a perceived inequity in provision of services exists. Louth and Grantham were identified as having a perceived gap in service commissioning relating to psychology.

11.2. Recommendation

11.2.1. These finding should be considered by the “Choosing Life” commissioning work stream within the County.

12. Benchmarking

12.1. There was evidence from quality reports to the FT Board in October 2014 that the Foundation Trust falls within the benchmark of acceptability at present. All benchmarking to date has been against the published National Reporting and Learning Service (NRLS) data for Mental Health Trusts. It should be noted that there is an underlying upward trend for suicide rates. It would be prudent to consider this as present assurances may need to be revisited.

12.2. There is a level of misunderstanding between commissioners and the FT about the data being used for benchmarking. Under the terms of reference this is not an issue I have pursued. I would suggest that an open dialogue between both parties ensues so agreement is reached.

12.3. Recommendation

12.3.1. Further discussion and agreement is required between the FT and Commissioners regarding data being used for suicide benchmarking.

13. Changed Practice

13.1. The FT has a newsletter **"Learning Lessons"** which **promotes c**hanges to practice. Some examples include access to Silverlink, inpatient observations and updating of risk assessments. **This is very pleasing to see** as all these themes have already been identified within this report. It is important that any cultural issues of receiving and implementing these changes are considered: a newsletter has the potential to inform but there also needs to be an evaluation of how it is being received and utilised so change is implemented and care improved.

13.2. It would be helpful for an evaluation of all action plans associated with the reports I have reviewed to be considered within the FT. I would suggest a mapping of this would be helpful to give assurance that actions have been completed and change has been implemented. This would add confidence within teams, build motivation and continue a process of culture change. It would also provide a further level of assurance to FT Board members and Commissioners.

13.3. Recommendations

13.3.1. Further consideration be given to evaluating the success of the "**Learning Lessons"** newsletter;

13.3.2. A mapping process of all action plans from reports considered in this review is completed which identifies actions completed and any outstanding gaps in implementation. Staff are congratulated on improvements they have made.

14. Governance

14.1. It would be remiss of me not to raise this as a separate point within this review. I had the opportunity to review the serious incident reports for a defined population within the FT. I found that in the majority of reports, terms of reference (TOR) were generic: there were few examples where TOR were bespoke to individual circumstances. The response to the duty of candour was also generic: there was no personalised response on an individual basis. It was obvious that some report templates had been cut and pasted. I would hope that this is a historical pattern of practice and that future investigations and associated documentation will be bespoke to the individual situation.

14.2. There was inconsistency in the quality of reports. It was obvious to the reviewer when staff had experience and knowledge of investigation procedure, report writing and action planning and those who were less confident. I would suggest that individuals who are less confident receive further training and work alongside individuals who have more experience to improve the overall standard of reports.

14.3. There was inconsistency in terms of sign off of all reports. The 2012 and 2013 reports had an executive sign off requirement which was inconsistently applied. This changed in 2014 and executive sign off was not required. It may be that delegated authority to more junior staff was agreed formally within the governance arrangements of the FT. However this was not obvious to myself: indeed if this had occurred staff signing off the reports were on a spectrum of seniority and experience. I remain unsure of the level at which these reports are being signed off by the FT Board, and would recommend that this concern is clarified swiftly.

14.4. I am aware that a review of the governance of serious incident reporting is ongoing within the FT and would request that these comments are used within that review.

14.5. Recommendation

14.5.1. The comments and suggestions made above are included and considered within the serious incident reporting governance review currently ongoing within the FT.

15. Good practice

15.1. Within this review there has been a propensity to concentrate on issues for improvement. However within the reviewed reports there were many examples of good practice, which I would wish to note and convey to the FT Board. In one report an occupational therapist was commended for their record keeping. Another example demonstrated that safeguarding procedures were followed meticulously to protect a child living in a chaotic home: it was fantastic care. There were three exemplary investigations and associated actions plans which should give great confidence that the FT could accelerate to a position of real strength and excellence in the knowledge of what needs to change.

16. Thanks

16.1. All staff I have met during this review have been welcoming, open and transparent in their conversations and information sharing. I am grateful for their time and consideration. I hope this report supports the continuance of a journey of clinical service transformation for service users in Lincolnshire supported by Lincolnshire Partnership NHS Foundation Trust and its associated Commissioners.

Mandy Ashton (Professor)

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