MEETING DATE:	12 February 2015	NHS North Lincolnshire Clinical Commissioning Group **REPORT TO THE** **CLINICAL COMMISSIONING GROUP** **GOVERNING BODY**
AGENDA ITEM NUMBER:	Item 7.9	
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	Catherine Wylie Director of Risk and Quality Assurance. CCG	

REPORT OF THE INDEPENDENT REVIEW OF MULBERRY WARD, GREAT OAKS

PURPOSE/ACTION REQUIRED:	The Board are asked to note the report and agree the monitoring plan for achievement of the recommendations.
CONSULTATION AND/OR INVOLVEMENT PROCESS:	All relevant agencies were consulted during the review
FREEDOM OF INFORMATION:	**Public**

1. PURPOSE OF THE REPORT:

This report provides the outcome of an independent review that was commissioned from NICHE patient safety by NLCCG.

The report was commissioned due to a number of concerns that had been raised with regard to the care at Great Oaks Mental Health Unit. The services at Great Oaks are provided by Rotherham Doncaster and South Humber NHS Foundation Trust.

The issues raised are as follows:

1. There had been six suicides of patients who were in patients at Great Oaks and were on leave at the time they took their life.
2. Figures submitted by the Police to the Local Authority showed a significant rise in incidents logged with regard to missing patients from the unit.
3. Concerns that under 18yr olds have been admitted to the unit
4. Concerns had been raised by Scunthorpe and District Branch of 'Mind' – Voice of Service Users.

The report concludes that there is no evidence that patient care on Mulberry ward is unsafe and safety has improved significantly since the summer of 2013. There are sound governance systems in place and the evidence demonstrates that the incidence of patient safety issues has reduced.

Twenty recommendations have been identified to further develop systems and processes and make improvements to quality and the patient experience and RDASH have developed an action plan to implement those changes. The action plan will be monitored through bot he Serious Incident group and the Quality Group and updates will be provided to the Board.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:

Continue to improve the quality of services	**X**
Reduce unwarranted variations in services	
Deliver the best outcomes for every patient	**X**
Improve patient experience	**X**
Reduce the inequalities gap in North Lincolnshire	

3. IMPACT ON RISK ASSURANCE FRAMEWORK:

Yes		**No**	**X**

4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:

Yes		**No**	**X**

5. LEGAL IMPLICATIONS:

Yes		**No**	**X**

6. RESOURCE IMPLICATIONS:

Yes		**No**	**X**

7. EQUALITY IMPACT ASSESSMENT:

Yes		**No**	**X**

8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:

Yes	**x**	**No**	

9. RECOMMENDATIONS:

The Governing Body is asked to note the findings of the report and approve the pathway for monitoring achievement of changes advised in the recommendations.

Niche
PATIENT SAFETY

Rotherham Doncaster and South Humber
NHS Foundation Trust

NHS
North Lincolnshire
Clinical Commissioning Group

Independent Review of safe practices in Great Oaks, Scunthorpe

1828-14
12th November 2014

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EXECUTIVE SUMMARY

Why we were asked to carry out this review

Niche Patient Safety, a specialist management consultancy, was commissioned to undertake a review of the safety and practices on Great Oaks unit. This report sets out the approach, findings and recommendations of the review. Both the CCG and the Trust wished to understand:

- whether the serious incident investigations were of a sufficiently robust nature when benchmarked against best practice;
- whether the internal investigation recommendations from the RCAs are reasonable;
- the extent of evidence for implementation and monitoring for embedded change;
- common themes and contributory factors from these cases;
- clear recommendations to improve safety and internal investigations where appropriate;
- summary of the organisational response leading up to the incidents occurring;
- whether safe practices are applied in the unit;
- how the Trust compares with other similar trusts; and
- recommendations regarding the future configuration and design of the unit/service, if the unit was unsafe.

Our findings

A thorough review has been undertaken of each of the above elements and has established that there is no evidence that Mulberry ward is unsafe and there are sound quality governances in place.

During the review, each patient spoken to, either individually, or as a group, indicated that they felt safe on the ward. The team also reviewed incident data, which indicated that there have been no reported serious incidents for Mulberry Ward since December 2013 and only one call to the Police. The team visited at different times of the day/evening and saw that patients and staff always interacted positively. Patients were visibly distressed or agitated at times and staff were noted to discuss issues with them, leading to calmer behaviour.

With regard to concerns raised by external partners; the police feel that the Trust has made significant efforts to improve the circumstances on the ward, that relationships have improved and there was much more opportunity to discuss and develop strategies for working together. In addition, they reported that there was much less support required from the local officers. There were positive indications from the Local Authority that they were also working better together.

The review has found that the Trust took action in 2011 after a negative report from the local involvement network, and continued to make changes to the governance processes and leadership of the adult in- patient team. The changes only began to have the right impact in the summer of 2013.

The review found that between July and November 2013, the Trust made significant changes to the leadership and introduced additional leaders. This then started to have an effect to the point that evidence of safer care started to be seen from January 2014 onwards. The impaired performance of the previous team in 2013 coincided with a particular case-mix of patients that may have created the circumstances for each of the serious incidents to occur.

The review also established that quality is discussed on a regular and frequent basis within the organisation, and there is a sound quality governance process in place. The systems and focus in reports at Board level recognise quality as being important, and board members visit Great Oaks on a regular basis. Whilst there are improvements needed to the Serious Incident investigation process there are also areas of good practice that the Trust can build on.

The Trust have made significant headway in raising the standards of care on the ward. However, the review team have made a number of recommendations that are aimed at further improving the quality of patient care, either directly or indirectly.

1. INTRODUCTION

1.1 Project Scope

NHS North Lincolnshire Clinical Commissioning Group (NLCCG) commission Rotherham Doncaster and South Humber NHS Foundation Trust to provide adult community and inpatient mental health services for the people of North Lincolnshire aged between 18-65 years old. Some of these services are provided from the Great Oaks unit in Scunthorpe.

Over the winter of 2013/14 a small cluster of serious incidents (SI's) happened to this patient group in the Great Oaks unit. The incidents and some other occurrences at the Great Oaks unit had given both the Trust and partners cause for concern about the safety and quality of the provision of inpatient services, in particular the risk assessment processes and the competence of those completing these within the service. The other occurrences were:

- local police reporting it could take up to four hours for a doctor to attend a Section 136 assessment at the unit
- police reporting an increase in absconsions in Quarter 3 last year (2013-14)
- local services users not feeling safe on the unit reported in a local patient survey
- concerns over the admission of under 18 year olds to the unit, and
- requests for transfer of challenging patients.

The Trust had provided a report on the common themes of the serious incidents above, and also reassured commissioners that it had reorganised the management of the unit. Nevertheless these concerns remained, and the local authority became involved in discussions with commissioners about the safety of patients.

Niche Patient Safety, a specialist management consultancy, was commissioned to undertake a review of the safety and practices on Great Oaks unit. This report sets out the approach, findings and recommendations of the review. Both the CCG and the Trust wished to understand:

- whether the serious incident investigations were of a sufficiently robust nature when benchmarked against best practice
- whether the internal investigation recommendations from the RCAs are reasonable
- the extent of evidence for implementation and monitoring for embedded change
- common themes and contributory factors from these cases
- clear recommendations to improve safety and internal investigations where appropriate
- summary of the organisational response leading up to the incidents occurring
- whether safe practices are applied the unit
- how the Trust compares with other similar trusts, and
- recommendations regarding the future configuration and design of the unit/service, if the unit was unsafe.

1.2 Approach

To obtain information and data to inform the review the following steps were taken:

- Site visit over 3 days.
- Face to face and telephone interviews with:

- patients
- Trust board members
- senior and middle managers
- commissioners
- frontline staff (in-patient and community staff)
- patient and carer representatives
- the police, and
- the local authority.

- Documentary review of:
  - Public and private Board papers
  - Assurance system
  - Board committee structure
  - Organisational management structure
  - Quality Improvement reports
  - Internal assurance visits reports
  - Clinical audit reports
  - Serious incident reports
  - Trust policies
  - Training and supervision records
  - Induction to Mulberry Ward pack for staff nurses
  - Patient case notes; electronic and paper
  - MDT minutes, and
  - External reports from service user groups, CQC etc.

A full list of documents is contained in Appendix A. Those involved in the process were informed that their comments would be protected as confidential, unless there was a whistle-blowing or public interest issue. The review team would like to thank those involved for their open and constructive approach to the review.

1.3 Context

On 1 August 2007, Rotherham Doncaster and South Humber Mental Health NHS Trust received authorisation and was granted Foundation Trust status, and in 2008 the Trust began managing all North Lincolnshire mental health services. In October 2010, the transfer of tier 2 and tier 3 CAMH services to the Trust took place, and in April 2011, a further 1,700 staff transferred in under the Transforming Community Services programme. The Trust was renamed Rotherham Doncaster and South Humber NHS Foundation Trust (The Trust) to reflect the range of services provided. The Trust now employs around 3,700 staff and around 115,000 people who access The Trust services each year. The Trusts operating expenditure on health and social care in 2013/14 totalled £156.8 million. The Trust has achieved all its planned financial targets every year as a Foundation Trust and is currently rated green for governance by Monitor, the independent regulator for Foundation Trusts[1].

The Trust headquarters are in Doncaster, and it provides services in 240 locations across Rotherham, Doncaster, North Lincolnshire, North-East Lincolnshire and Manchester. These include inpatient and hospital-based mental health services at Great Oaks in Scunthorpe. The area around the Great Oaks site in Scunthorpe is fairly economically deprived and the

[1] *https://www.gov.uk/government/publications/nhs-foundation-trust-directory/nhs-foundation-trust-directory#foundation-trust-ratings*

main local industry is steel processing. Scunthorpe itself is heavily industrial but is surrounded by farmland and wooded areas.

In terms of general location it is some distance away from other towns such as Hull and Grimsby. This location and geography has made it difficult to recruit new nursing and medical staff, and has resulted in a low turnover of professional staff in the Great Oaks unit.

2. ANALYSIS

The analysis of the information collected was completed in three parts.

2.1 Site visit

The first part of the review was to determine the safety of patients. This was in the form of a site visit, conducted over three days. The review team wished to observe the patient care areas, observe interactions between patients and staff, and review certain documents on site. The team were present on the ward for approximately 12 hours in total and had the opportunity to observe the ward at different times of the day and evening. No night shift visit was completed. Key lines of enquiry followed included the safety of the patients, the quality of risk assessment, care planning and therapeutic intervention. The review team also benchmarked the Trust against similar sized 'nearest neighbour' Trusts on publicly available data on safety and quality.

2.2 Serious Incident Process Review

A small cluster of serious incidents (SI's) had given rise to concerns about the safety and quality of inpatient services, in particular the risk assessment processes and the competence of those completing these. There had been seven suicides and one AWOL with serious consequences between April and December 2013. These eight incidents were subject to review using the following criteria:

- identify common themes and contributory factors
- consider whether the investigations were of a sufficiently robust nature when benchmarked against best practice, and
- whether the internal investigation recommendations are reasonable.

The review team analysed the internal investigation and action plan for each incident for comprehensiveness, assessing the investigations to see if they had covered appropriate areas and concerns and whether the recommendations were robust and reasonable.[2] The team have also benchmarked the investigations against NPSA best practice guidelines[3] and reviewed evidence of implementation for each of the incidents, assessing completion and monitoring processes.

This review was a combination of desk-based analysis and site visits and interviews. The review team has spent time at the unit to understand the investigation process and teams involved, and also to review the evidence for implementation of action plans. This involved visiting the inpatient ward, meeting with inpatient and community service users, ward nursing and medical staff, Mulberry Ward Manager, Service Manager and Locality Manager, nursing and medical staff from the Access, Crisis and Recovery teams.

The SI process review included a thematic analysis of the demographic and clinical detail and root causes, exploring and identifying common areas where these arose, and seeking to identify contributory factors.

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[2] *RCA Investigation Evaluation checklist, tracking and learning log. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847*

[3] *Independent investigation of serious patient safety incidents in mental health services; good practice guidance. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847*

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2.3 Management and assurance systems

The final part of the review examined the management and assurance systems that were in place and how they had been utilised. This was completed initially by reviewing the documents received and the interview and observation notes made through the review, and developing a chronology to identify key points and occurrences. From this a timeline of issues, incidents and reports was developed. This was then refined by judgement, identifying occurrences that were deemed to have had a material effect on the patient outcome.

3. FINDINGS

The findings for this report echo the three part process and cover facts and contributory factors:

1. Safety and care of patients on Mulberry Ward (including external benchmarking);
2. Serious Incidents process; and
3. Management and Assurance systems.

3.1 Safety and care of patients on Mulberry

Great Oaks unit is an in-patient and community facility. There are two wards, Mulberry and Laurel. Laurel is an older people's mental health ward and was not visited as part of this review. Mulberry is a 19 bedded ward providing inpatient care and treatment for adults experiencing an acute episode of mental ill health. Some patients may be detained under the Mental Health Act. During the summer of 2014 there had been concerns raised via the Police and Local Adults Safeguarding Board about the safety of patients on Mulberry Ward at Great Oaks, specifically referring to incidents over 2013 and 2014, some of which are detailed in the section above. There were comments via patient representatives that patients were complaining of not feeling safe on the ward, combined with a high number of calls to police about the safety of patients and issues of safety on the ward. The review team investigated this as a key line of enquiry during their visits to the ward. The team also reviewed patients' case notes, the activities and general care delivered.

A perception was also evident within social services gained from frontline staff that the therapeutic input on the ward was poor, and there was no evidence to the contrary.

The team had the opportunity to speak with several patients as a group in the meeting room without staff present, and then at various times throughout the visits. Every patient indicated that they felt safe on the ward. They were generally satisfied with the care and compassion shown by staff. However, they did complain a lot about the lack of activities and day time occupation. They were also very unhappy about the fact that the washing machine had been inoperable for 4 weeks and stated that the food was not good.

The team met with a group of community service users, all of whom had either personal experience of Mulberry ward, or of access to community services. Those who had been inpatients complained of a lack of meaningful or therapeutic activities. Whilst agreeing that admission was required to keep them safe, they were then surprised that the level of care provided by Mulberry ward did not feel as though it was the most intensive. All were very positive about their experiences of access, recovery and home treatment teams.

Discussion with the Police and the Local Authority identified that during the first half of 2013/14 they were becoming increasingly concerned about the way the ward was being managed. During the interviews people described senior officers saying it had been 'mayhem' and 'chaos' on a regular basis, with numerous calls to the police to either report patients missing or call for assistance on the ward.

Since December 2013, the police feel that the Trust has made significant efforts to improve these circumstances on the ward. They felt that relationships had improved and there was much more opportunity to discuss and develop strategies for working together. In addition they reported that there was much less support required from the local officers. For example in quarter 3 (October – December 2013) the police were being called every day for help and since April 2014 there had only been one call. There is now an agreement between the Trust and the police about how long the police have to wait with a patient when placed on a section 136 and the police feel that the situation is much more positive. Evidence supplied by the Trust indicates that 82% of all S136 assessments are now seen within 3 hours. During the interviews it became clear that there were also positive indications from the Local Authority that they were working better with the Trust.

A review of the statistics for Mulberry ward for the past 3 years identified that there were 4 serious incidents and 5 complaints in 2011/12; 3 serious incidents and 11 complaints in 2012/13 and 8 serious incidents, one on Mulberry and one on Brodsworth Ward of a Nth Lincolnshire patient and, 17 complaints in 2013/14. In addition there were three incidents in 2013 (March – August) which were cases of under 18s being admitted to an adult bed. This pattern coincides with a local lack of capacity in CAMHS beds, which is also recognised as a national problem. The review team heard from several people inside the Trust that the admissions were carefully risk managed, the decision to admit was made at a senior level and was in the patient's best interest as there was no nearby alternative. It was important to include this in the report as it was an issue repeatedly referred to during the interviews However, it should also be noted that the provision of care for under 18 years is a National issue and is being reviewed by NHS England.

3.2 Benchmarking

The review team completed an analysis of public domain benchmarking data about the performance of the mental health services provided by the Trust. It contains data on three topics:

1. The CQC's community mental health survey has been used as it is the only public domain and benchmarkable dataset describing the patients' reported experience of using services provided by the Trust. This survey may have identified problems from community patient perspective that may form a line of enquiry for the inpatient services.
2. The annual survey of staff opinion of the Trust as a place to work, and of the Trust's services.
3. Safety and incident data gathered by the National Reporting and Learning System

The analysis benchmarked the Trust's performance against both all-England data where relevant, and the performance of those mental health Trusts which serve the communities which are statistically the most similar to the Trust, using CIPFA's nearest neighbours model[4]. These are:

- 5 Boroughs
- Dudley and Walsall

[4] *CIPFA nearest neighbour's model allows the user to choose social characteristics of a local authority and find the other local authorities with the most similar social characteristics to the authority selected. In this instance, the review identified the nearest neighbours for Rotherham, Doncaster and South Humber, then looked for mental health trusts providing services to other similar areas.*
http://www.cipfastats.net/resources/nearestneighbours/profile.asp?view=select&dataset=england

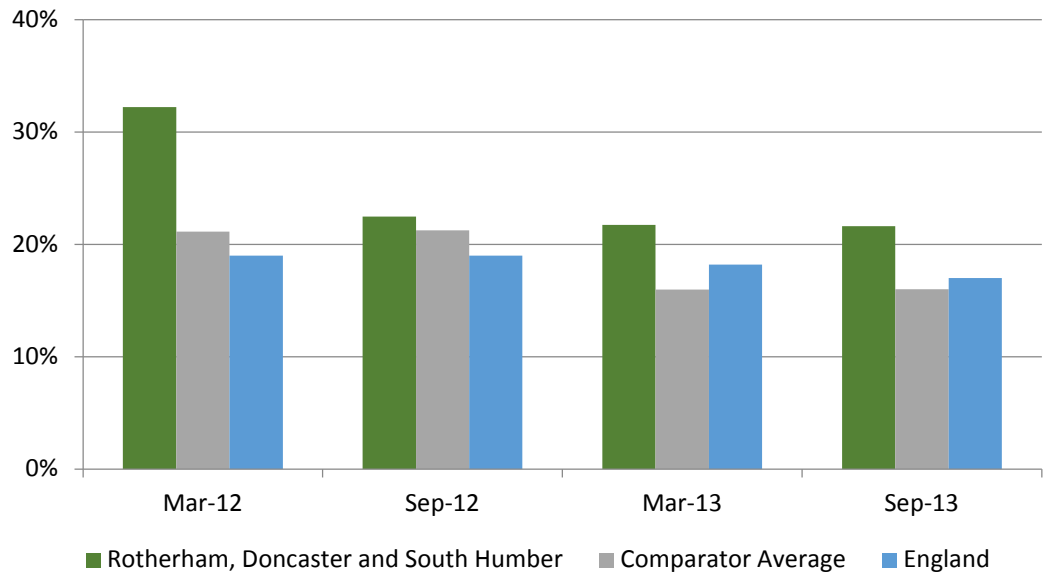
- Greater Manchester West
- Pennine Care
- South West Yorkshire
- Tees, Esk & Wear Valley

The review also benchmarked the Trust against a basket of other Yorkshire 'peer group' mental health Trusts:

- Humber NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Sheffield Health & Social Care NHS Foundation Trust

Compared to the other Trusts within this comparator group the Trust performance is relatively good. The Trust patient survey benchmarks very well and the staff experience is positive overall. The Trust report more incidents[5] more quickly than their comparators, they have a higher proportion of low and no harm incidents, and a lower level of moderate and severe harm, which are signs of a positive patient safety culture. The Trust also compares well in terms of admission and discharge incidents, medication errors and self-harm. The only point to note was that, RDASH report higher levels of disruptive and aggressive behaviour than their comparators; this has been consistent over the past two years. This may need to be investigated further by the Trust. See fig 1 below.

Fig 1: Aggressive and disruptive incidents reported.



Patients are generally more satisfied than patients of the comparator Trusts and this was echoed in the team's discussion with community patients. The full detail of this analysis is in Appendix B.

Recommendation 1. The Trust should investigate to understand the reasons for the activity shown in figure 1 above.

[5] *High numbers of incident reporting is seen as a positive indicator of a safety culture.*

The review team also looked at safeguarding activity on the ward. The review team could see from records supplied that 92% of staff at Great Oaks had attended safeguarding level 1 training in 2013/14. There was very little in the way of evidence of practice on the ward, for example an easy-read leaflet for patients or a flow chart for staff to follow. However, patients we spoke to could describe who to talk to if they felt vulnerable. One patient did describe having done this recently on behalf of another patient.

The team reviewed the risk assessments for a sample of patients, Functional Analysis of Care Environments[6] (FACE) risk assessments had been completed for all patients reviewed. In addition it was clear whether a patient was allowed escorted or unescorted leave. There are other observations regarding clinical risk assessment below, but from an immediate safety point of view the risk assessments had been completed satisfactorily.

During the teams visit the ward appeared to be clean, calm and comfortable. Male and female bedrooms were clearly identified and separate and there was a female only lounge. Some activities such as physical health monitoring were being completed, and there were obvious signs that staff were completing planned patient observations. The team visited at different times of the day/evening and saw that patients and staff always interacted positively. It was noted that patients were visibly distressed or agitated at times and staff discussed issues with them, leading to calmer behaviour.

There appeared to be enough staff on duty to respond to patient needs which in the review teams opinion meant that staffing was safe. However, most of the daytime Registered Nurses and medical staff were in the office. There are no national recommendations on staffing levels or skill mix in mental health, although this being developed by NICE, and the Trust are involved in these developments. The Trust has recently reviewed its ward staffing levels and set Mulberry's minimum safe staffing at 2 RNs per shift. This was discussed in the interviews and the review team clarified that the standard was for ***safe minimum*** staffing, not the optimum level for the ward. There were mostly around 2 RNs on duty and made up 40% of the staffing supplied. However it is known that an increase in the qualified staff ratio to unqualified staff is likely to lead to an improvement in the planning and delivery of patient care to more optimum levels. The less qualified the workforce the less qualified the interventions will be and there is less chance of doing the right thing in the right place at the right time according to high quality care principles.[7] This staffing skill mix left a lot of the direct patient care to nursing assistants during the day. There was a strong medical presence on the ward, and interactions with patients appeared positive. There were visits during the day from other professionals such as the dental service, clinical audit team and community staff.

The team observed the bedrooms, the 136 suite and the seclusion room. Most of the patient areas appeared to be ligature-point free, with specially designed furniture, doors and door handles. The review team were informed that the Trust uses a ligature point assessment framework regularly. The review team applied the Manchester ligature framework[8] and also their own professional knowledge and experience to an assessment of ligature points as they visited the ward.

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[6] *Clifford, P.L. (1999). "The FACE Recording and Measurement System: a scientific approach to person-based information". Bulletin of the Manager Clinic*
[7] *Compassion in practice (2012) NHS England www.commissioningboard.nhs.uk*
[8] *Preventing Suicide by Hanging and Asphyxiation: :Ligature Audit Tool (Greater Manchester West NHS Foundation Trust) 2009*

Taps were observed in one of the bedrooms that would provide a ligature point, and there was opportunity to make a ligature point from the outside fencing. This was discussed with the ward sister, as the review team felt that the presence of taps in one bedroom undermined the good work that had already been done to reduce or manage ligature risks. The team received reassurance that this would be discussed with the ward manager at the next opportunity.

Recommendation 2. The Trust should ensure that the ligature point risk assessment is reviewed.

The locked door policy was reviewed and at the time of all 3 visits, the ward was operating a locked front door practice. Patients and visitors had to ask to be allowed out, staff could leave with an electronic fob. This contravened the Trusts own policy as it appeared to be operating all the time, and there was no notice displayed for the reasons for the door being locked, or how this may affect informal patients.

It is the review team's view that the ward appears to be safe, that patients state they feel safe and the ward appears to be calm and clean.

3.3 Therapy and treatment

The review team reviewed plans and notes for 12 service users whilst on the ward. These were stored on the 'Silverlink system' and were in two phases of development. In all cases each section of the care record had been opened and many had been completed. However, the detail within the documentation was often limited, and meaningful nursing care plans were not common. The risk assessment section was completed in all cases. This provided some overview of the risks the patient's illness or behaviour posed. However it lacked detail and in some cases the quality of the assessment appeared poor. In particular, there appears to have been a focus on 'ticking the boxes' for the risk assessment, but the assessments lacked narrative descriptions or consideration of dynamic factors likely to influence risk. There was also rarely any detailed description of the planned interventions for managing behaviour. The detail of the 12 care records is shown below.

Case number	FACE assessment	Physical assessment	Nursing interventions	Recovery plan	Activities plan	1-1 every week
1	√	X	√	√	X	√
2	√	√	X	X	X	√
3	√	√	X	X	X	√
4	√	√	√	√	X	√
5	√	√	√	√	X	√
6	√	√	√	X	X	√
7	√	√	√	X	X	√
8	√	√	X	X	X	√
9	√	√	X	√	X	√
10	√	√	X	√	X	√
11	√	√	X	X	X	√
12	√	X	X	X	X	√
Total	**100%**	**83%**	**41%**	**41%**	**0%**	**100%**

A member of the review team attended an MDT handover, and heard discussions about how to manage the risks around a patient going out on leave over the weekend, and another who made frequent threats to harm himself. Following this meeting the team checked their care plans, both sets of records had clear care plans to guide staff decision making and manage contingencies. Whilst this was evidence of good practice, this was not the case for other patient's records on the ward.

From reviewing the SI reports issues of communication (including professional conduct) were identified 12 times. Inter-team communication was identified during the interviews as having been a problem over the course of 2013. The review team found that the inter-team and multi-disciplinary communication appears to be vastly improved since the cluster of incidents being reviewed. The nursing team meet on a Monday with the inpatient medical team, the community team and the occupational therapist to review all patients and discuss plans for patients for the week. This is followed up by a ward meeting on subsequent weekday lunchtimes to handover and update. The nursing staff were able to describe the approach being taken on the ward with each patient, and the plans that had been discussed at MDT. However, there was little documentary evidence of this multi-disciplinary risk assessment and subsequent care planning in the patients' notes.

The quality of risk assessments and care plans had been repeatedly identified as an issue when the ward came to moving patients on from in-patient care. Record keeping and the quality of risk assessments and/or care plans was a reoccurring recommendation in all of the SI reports in this review. Commissioners also report that it is difficult to make a decision about moving a patient to the recommended care placement because the clinical risk assessment is often inadequate or the on-going plan does not aim for or address recovery. This appears to be supported by the lack of evidence that the review team found in patients notes on the ward. This can lead to a difference of opinion and delayed discharges. The ward team are attempting to address this and meet regularly with commissioners to resolve ongoing placement issues. However the review team believe that improving the risk assessment and care planning practice and documentation on the ward will make more of a difference to what happens to patients. It was reported that there is a CQUIN scheme underway to improve care planning.

The team reviewed the training activity and compliance for the staff team on Mulberry. The ward team appears to have regular training allocated on the staff roster. These were in evidence in the training matrix that the team reviewed. We noted that the Trust had instigated a bespoke records management and care planning training programme in 2013/14. However, given that record keeping has been such an issue, the review team would have expected a more sustained focus on record keeping training. Of the 44 staff in the team only 5 had completed record keeping training in the last 12 months, however it should be noted that the programme is a three yearly requirement which may alter this figure; 9 had completed training on the Silverlink system. It was reported that the Trust is reviewing its mandatory training programme and refreshing the training for staff on record keeping, it unfortunately had not had an impact at the time of the review.

The team reviewed the clinical audit results for Mulberry to see if record keeping had been better at other times. The ward results, in April 2014, showed 100% of FACE assessments had been completed, and a number of other criteria were compliant. However there were gaps in recording carers' involvement, the types of risks that a patient would pose and the detailed plan to manage these risks. Elsewhere in the reports, the team found there was

evidence that 83 out of 88 in patient staff have attended risk assessment training in the last 12 months. Another record keeping audit that was completed in April 2014 was disregarded by the team as the sample size was too small to be of use.

The team also reviewed incident data, which indicated that there have been no reported serious incidents for Mulberry since December 2013 and only one call to the Police.

Overall this indicated that the clinical risk assessment/management process was occurring as all staff interviewed were able to describe the process, and given that there have been no incidents, has been effective. However, as this process is not documented in sufficient quality and depth to ensure continuous effective risk management or to contribute effectively to moving along the care pathway, it could impact future patient safety and service failure risks.

Recommendation 3. The Trust should focus on rapid improvement of record-keeping, and improving the depth and quality of written risk assessment and care plans.

The review found that plans to deliver therapeutic interventions to the patients were limited. There is one session a week from psychology, which the review team felt was inadequate for a ward of this type. The use of psychological assessment and subsequent plans were not in evidence. The ward nursing staff receive team clinical supervision from the psychologist weekly and this was welcome, but attendance was variable. The Trust has recruited 2 psychologists for North Lincolnshire, who will provide some input into Great Oaks once in post.

The recovery concept was described in the ward induction booklet, and there is the opportunity to record a wellness recovery action plan in the Silverlink system. However the team found that this was not completed with sufficient depth and range to be useful. Daily records of interaction with patients were in evidence, and every patient had entries made on a regular basis. One to one time with a member of staff was offered on a regular and frequent basis to patients. However the entries that were made were often limited and offered little in the way of assessment of mood or progress towards recovery. It appeared that many of the entries were made by nursing assistants, and there is no functionality on Silverlink for a registered nurse to sign the entry off before it is saved.

On the days that the team visited the patients were not all out of bed until late in the day. There was an activity schedule planned by Occupational Therapy but it was not clear if it was always followed. There was also an extra nursing assistant, each shift, who was allocated to ward activities, which tended to be diversional such as art or quizzes. This responsibility appeared to be rotational, with duties allocated on the day, rather than a structured and considered approach to a treatment programme. There were some activities in evidence; more so in the evening. There were no written activity plans in any patients notes that the team reviewed, and where there was written confirmation that an activity had taken place, it was not clear what benefit this had on the patient mood or mental state. The team were not able to find any policy guidance on structured patient/service user occupation. Occupational therapy is recognised as an approach that uses activity to promote good mental health, assist recovery and help people achieve personally meaningful outcomes such as employment, self-care and leisure. Timely occupational therapy interventions can prevent unnecessary hospital admission, decrease the number of incidents on in-patient

wards, facilitate early discharge and support adults of working age to retain their jobs during an episode of mental illness.[9]
One issue that was raised and addressed while the team were visiting Mulberry ward, was the lack of a functioning washing machine. Patients reported to the team that the machine had been inoperable for four weeks and they had little other opportunity to wash their clothes. The patients were visibly upset at this. The team brought it to the service manager's attention and the washing machine was in working order at the team's next visit, a week later. However, the patients had nowhere to wash clothes for four weeks, although they were offered time to wash them on a neighbouring ward if there were enough staff to accompany them. It was slightly concerning that the ward staff did not appear to be actively looking for a solution to this, as the review team felt it could cause dignity/self-esteem problems for patients that had not got clean clothes.

The team observed patients being able to make their own drinks in the kitchen and heard from patients that they had on occasion made meals on the ward. The review team also took the opportunity to have a meal with patients on one day. It was surprising to see that all patients had to leave the ward to go for lunch in a dining room near the ward, at 11.55am.

This appeared to be the case even if someone was very unwell. Whilst the review team had no complaints, some patients did not like what was offered, in terms of quality or quantity. One patient described the typical evening meal, saying that they had usually eaten a light meal by 5.00pm and did not have any more food until breakfast the next day, and were often hungry. The team found the whole process quite institutionalised, and patients were almost all back on the ward by 12.15. The NHS introduced protected mealtimes in acute physical health services as part of the Better Hospital food programme[10] and, although practice is variable across the NHS, some mental health Trusts have chosen to implement the system as well. Mealtimes are not only a vehicle to provide patients with adequate nutrition but also provide an opportunity to support social interaction amongst patients and get the benefit of the therapeutic role of food within the healing process.

The review team found that there was not enough therapeutic intervention on the ward to help patients towards recovery. In particular the psychology input to the ward was inadequate.

Recommendation 4. The Trust and the CCG should work together to improve the psychology input and the number of therapeutic activity sessions offered on the ward. Validate the impact of the improvements through patient feedback.

3.4 Serious Incident Process

A desktop based review of the eight SIs was undertaken using best practice guidance as a benchmark, to assess the internal investigations for completeness and robustness and to more fully understand common themes and contributory factors. [11, 12]

The review has:

[9] *College of Occupational Therapists, 2012, Fact Sheet.*
[10] *NPSA (2008)Protected mealtimes review – Findings and Recommendations HMSO*
[11] *RCA Investigation Evaluation checklist, tracking and learning log. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847*
[12] *Independent investigation of serious patient safety incidents in mental health services; good practice guidance. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847*

- analysed the internal investigation and action plan for each incident for comprehensiveness
- assessed the investigations to see if appropriate areas and concerns have been covered
- considered whether the recommendations are robust and reasonable
- benchmarked the investigations against NPSA best practice guidelines
- considered evidence of implementation for each of the incidents, assessing completion and monitoring processes, and
- undertaken a thematic analysis of the findings of the eight investigations reports identifying common areas where these arise, and seeking to explore common themes and contributory factors.

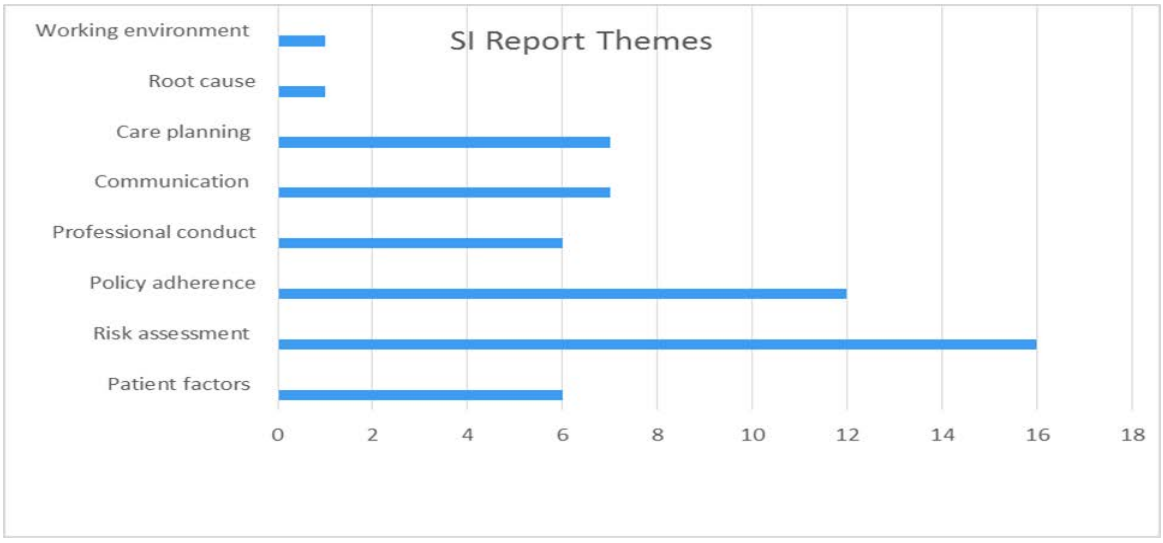
The review team have visited the inpatient ward, and met with:

- inpatient and community service users
- ward nursing and medical staff
- Great Oaks Ward Manager
- Service Manager
- Locality Manager, and
- nursing and medical staff from the Access, Crisis and Recovery teams.

3.4.1 SI thematic analysis of findings and contributory factors

Individual contributory factors and findings from the eight SIs were analysed, amounting to 63 in total. These were grouped into eight themes. Figure 2 shows the number of findings within each theme. The detail explained below refers to the themes reported in the Trust SI report findings.

Fig 2: Serious Incident report findings



Of the 63 separate findings, 28 of these factors, or 44% of the total, were concerned with policy adherence and risk assessment. Within each of these themes, the review team identified subcategories where these themes could be grouped together:

Risk assessment (16)

- making a full/thorough risk assessment 7

- reviewing risk assessments 4
- rationale for and documentation of changes 2
- lack of structured risk assessments 3

Policy Adherence (12)
- Failing to follow policy 8
- Standards 'not high'; engagement, record keeping 4

Communication (7)
- Clear communication with families 2
- Unclear handwritten documents 2
- Records split across paper and electronic 1
- Communication across and between the services 2

Care planning (7)
- No relapse plan 1
- No formulation 1
- No family involvement in care 1
- Delay in transfer to suitable care environment 1
- No review of refusal to involve family 1
- Medication review not timely 1
- OT assessment and intervention not timely 1

Patient factors (6)
- Young single male with distressing psychotic beliefs 1
- Difficulty in engagement 1
- Substance or alcohol misuse 4

Professional conduct (6)
- Little evidence of ward staff attempting to engage 1
- Conversations not captured in records 1
- No systematic follow up 1
- Record keeping brief, perfunctory, observational 2
- No clear nurse in charge identified 1

Working environment (1)
- Patient numbers exceeding bed numbers

Root cause references (8)
- Delay in transferring to a locked rehabilitation unit 1
- No root cause identified 5
- Awaiting coroner's decision 2

From this analysis it is clear that adherence to policies and practices around assessing and managing risk are key contributory factors in these eight SIs. Issues of management and leadership have been recognised by the Trust, and action has been taken since this time, as discussed elsewhere in the report.

Failing to follow policy has the highest incidence of any contributory factor. A review of recommendations and action plans for this theme demonstrates a variety of remedial

interventions, including discussion, training, reminders to staff, and raising in supervision. There are three instances where referral for management action is recommended.

The action plans reviewed do not contain any evidence of the lessons learnt from 'management action', and while it may be tracked through HR structures, there remains an uncertainty about the completed actions taken and evidence. This makes it difficult to track if lessons are being learnt and shared within the organisation. The review team notes that more detail in this action may have an impact on Human Resource processes and confidentiality and this should be borne in mind with regard to the following recommendation.

Recommendation 5. The Trust should ensure that management action relating to staff performance is reflected appropriately in the SI action plan monitoring process to ensure that tracking of actions and learning lessons is clear.

It is significant that only one of eight investigation reports identifies a root cause. A working definition of a root cause is:

The prime reason(s) why an incident occurred. A root cause is a fundamental contributory factor. Removal of these will either prevent, or reduce the chances of a similar type of incident from happening in similar circumstances in the future.[13]
NPSA 2008.

The root cause that was identified was '*delay in transferring patient to a locked rehabilitation unit'*. The review team would consider this to be a contributory factor, rather than a definitive root cause. The root cause could be discovered by exploring the causal chain of events by using an analysis tool such as the 'five whys'. By asking 'why' the transfer was delayed, a deeper understanding of the sequence of events could be uncovered, and remedial actions taken to prevent future occurrences.

Two of the suicide investigations state that a root cause cannot be given until after the inquest. The cause of death would not be regarded as a root cause of the incident. The review team have been informed that a cohort of staff have undergone RCA training, however it may be that this training does not provide the skills and knowledge to identify a root cause. It may also be the case that the process does not draw out or require the root cause to be identified. For example, the policy document does not describe a root cause in the same way as the NPSA definition above, and whilst it references the tools that can draw out a root cause there is no description about how to use them.

Recommendation 6. The Trust should revisit the training that investigators have to ensure that root cause analysis is correctly covered and ensure that the policy/process for serious incidents describes a root cause correctly and how to identify it.

In the Trust policy for managing serious incidents (section 5.3 page 10) there is a requirement for Assistant Directors to complete a checklist for each report, with the aim of monitoring and managing quality of reports. However, from analysing the quality of the reports against the items on the checklist it appears that this system is not being followed,

[13] *Root Cause Analysis glossary http://www.nrls.npsa.nhs.uk/resources/?entryid45=75602*

as only 2 of the 8 reports (both from Feb 2014) had a signed off AD checklist and CEO 'sign off for submission', and is therefore not effective in ensuring the quality of reports.

Recommendation 7. The Trust should ensure that the Assistant Directors checklist is completed and used to assure the quality of reports.

3.4.2 Individual profiles of the SIs

steis	age	gender	diagnosis	section	method	service	O/L at SI	last seen	SI date	place	previous DSH/ suicidal ideas
10414	30	male	psychotic beliefs suicidal ideation	inf	hanging	inpt GO	yes	6/4/13	8/4/13	home	YES -S
15660	52	male	depression & bipolar	n/a	hanging	HBT	n/a	25/5/13	26/5/13	cemetery	YES S&D
20499	24	male	mental & behavioural disorder due to multiple substance misuse- psychotic symptoms polymorphic	n/a	hanging	recovery	n/a	3/7/13	12/7/13	home	YES S&D
28957	37	male	paranoid schizophrenia		jump	inpt GO	yes	2/10/13	2/10/13	bridge	YES- DSH
29127	29	male	paranoid schizophrenia & comorbid drug & alcohol misuse	3	awol	inpt GO	awol	2/10/13	2/10/13	road	NO
34699	35	male	schizophrenia	3	rta	inpt Don	yes	23/11/13	23/11/13	road	YES-S
36044	37	male	none	n/a	hanging	access	n/a	29/11/13	30/11/13	home	NO
37283	29	male	paranoid schizophrenia	3	jump	inpt GO	yes	17/12/13	17/12/13	bridge	YES- S&D

3.4.3 Demographics and comparative details

From the analysis of the individual characteristics, some clear similarities are evident. All of the incidents concern males between the ages of 24 and 52. This is perhaps unsurprising, as the majority of suicides continue to occur in adult males, accounting for approximately three quarters of all suicides (77%)[14]. Six of the eight patients were diagnosed as having a psychotic disorder, with only two who showed signs of low mood or depression (one did not yet have a diagnosis but had clear losses and adjustments as factors). Four had a history of suicidal ideas and self-harm, and two had a history only of previous suicidal ideas.

Hanging accounts for four of the seven suicides, again reflecting national trends, as shown below.

[14] *Department of Health Statistical update on Suicide 2014*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278120/Suicide_update_Jan_2014_FINAL_revised.pdf

Source: ONS (ICD10 X60-X84, Y10-Y34)

Two of the patients jumped from the Humber Bridge. More than 200 incidents of people jumping or falling from the Humber Bridge have taken place since it was opened in 1981. There is currently a campaign for suicide prevention interventions at the Humber Bridge, such as fencing, barriers and a suicide hotline.

Recommendation 8. The Trust and CCG should continue to support the campaign to put suicide prevention interventions at the Humber Bridge.

The above picture suggests a need for a heightened awareness of risk factors for men referred to mental health services, with the inclusion of flags or indicators for heightened risk of suicide in triage and risk assessments.

The Samaritans[15] research into men's suicide suggest these areas for action:

- Suicide prevention policy and practice must take account of men's beliefs, concerns and context – in particular their views of what it is to 'be a man'.
- Recognise that for men in mid-life, loneliness is a very significant cause of their high risk of suicide, and enable men to strengthen their social relationships.
- There must be explicit links between alcohol reduction and suicide prevention strategies; both must address the relationships between alcohol consumption, masculinity, deprivation and suicide.
- Support GPs to recognise signs of distress in men, and make sure those from deprived backgrounds have access to a range of support, not just medication alone.
- Provide leadership and accountability at local level, so there is action to prevent suicide.

Recommendation 9. The Trust should review the clinical risk management/suicide prevention policy to include the risk factors for men.

The Suicide Prevention Policy clearly outlines the elements of a comprehensive clinical risk assessment, with rich information to support staff in the recognition of risk, and assessment and prevention of suicide. There is however a statement that there is:

'*no specific training programme that is required for the use of this policy and the appended audit tools'*.

[15] *Men and Suicide http://www.samaritans.org/sites/default/files/kcfinder/files/Samaritans_Men_and_Suicide_Report_the review b.pdf*

The expectation is that:

'*Service Managers will inform all clinical practitioners delivering clinical services of this policy and make them aware of the policy and its contents. They will identify those employees that require specific training within their services and take the necessary action for them to attend the appropriate training'.*

Whilst we recognise that STORM training is offered by the Trust, given the frequency and severity of the incidents, there clearly is a need to train more staff in the policy and in suicide prevention.

Recommendation 10. The Trust training needs analysis should be reviewed to include training on suicide prevention. The suicide prevention policy should then be amended to reflect the needs analysis.

3.4.4 Leave from the ward/AWOL

Initial concerns were that the suicides were all committed by in patients who were on leave. However half of these (four of the seven suicides) were in-patients on agreed leave; one of these was in Brodsworth ward, Doncaster, and three in Great Oaks. The patient who went AWOL was also an in-patient at Great Oaks.

The 'Policy and guidance on the granting of leave for in-patients (including section 17 guidance)' was reviewed, reflecting on these events.

Detained patients:
The policy sets out the responsibilities of the Responsible Clinician (RC) in making decisions about leave for detained and restricted patients, and gives a list of what needs to be considered prior to leave being granted. There is no clear guidance for registered nurses in making decisions about when leave may be agreed on request, and what risk assessments should be carried out. It is not clearly stated that the nurse in charge must make the decision, following a risk assessment.

In practice the review team found that staff nurses were completing an electronic 'mini mental state assessment' before a patient went out on leave. This concentrated on mental state and presentation on the day, and did not consider dynamic factors that may impact on risk presentation.

Informal patients:
Guidance focusses on factors the multi-disciplinary team (MDT) should consider when granting leave, and states the ward round or MDT meeting is the *'best forum for deciding on leave of absence'*. The responsibility for making the decision is not clearly defined, but it is implied it will be made by the MDT.

If a patient asks for leave outside of the MDT meeting, the policy states *'on these occasions the nurse in charge should discuss the appropriateness of leave with a member of the medical team and consider points 5.1.5 (risks/benefits) before a decisions is taken to grant*

leave'. It is not clear who is responsible for making the final decision. If the patient still wants to leave despite the judgement of medical and nursing staff that they should stay in hospital; '*leave should only be agreed after a full assessment of the risk and benefits and a record of the decision must be made in the medical notes'* . This again implies, but does not clearly state, that medical staff will make the final decision.

This is the only statement in the Policy about the requirement for a nurse to make a full assessment of risk before agreeing leave.

The policy states '*there are no separate identified training needs in respect of the contents of this policy, as an explanation of section 17 leave of absence is included in the Trust Mental Health Act training'.* The review team recommend that this is reconsidered, as making risk based decisions about leave is a key skill, and requires a further depth of knowledge than just an understanding of section 17 alone.

Recommendation 11. The Trust should review the leave policy and include clear responsibilities for decision making and recording by doctors and nurses in charge, with an agreed set of risks to be assessed which include static and dynamic factors. Skills-based training in the application of this policy should be should be made available.

3.4.5 Investigation report credibility and thoroughness

The NPSA Report Credibility and thoroughness Criteria tool was used to quality assure each individual report. The full report is contained in a separate confidential spreadsheet. The overall score is shown below 51.32%.

Summary of Investigation Report Credibility and thoroughness Criteria

NHS National Patient Safety Agency

Event Type	Incident	Claim	Complaint	Concern	
Number of event type	8	0	0	0	
Incident / event Severity	No Harm	Low Harm	Moderate	Severe	Death
Number of incident/event severities	0	0	1	0	7

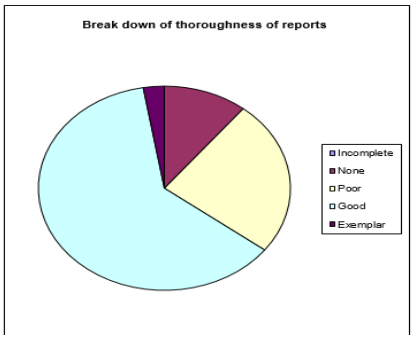
Number of reports evaluated	8
Overall score for all reports evaluated	51.32%

Break down of thoroughness of reports

To show what your overall score above means... This breakdown helps to distinguish between all reports scoring 50%, or half scoring 0% and half scoring 100%

Level apparent from the Report				
Incomplete	None	Poor	Good	Exemplar
0	32	73	184	8

Investigation Outcome Criteria	Yes	No	N/A	Total
Has the Action Plan been implemented?	6	2	0	8
Has the Action Plan been signed off?	5	3	0	8
Have root causes and/or learning points been shared (locally, across the organisation, and nationally) for learning purposes, as planned and	8	0	0	8
Has a post implementation Impact Analysis been conducted to assess actual levels of risk reduction	0	8	0	8
Is there a demonstrable reduction in frequency of recurrence of this incident/claim/complaint type as a result of actions taken?	3	5	0	8
Is there a demonstrable reduction in severity of this incident/claim/complaint type as a result of actions	3	5	0	8
If you answered no to Q 2.8 + 2.9 above, Can you now identify and implement changes that you beleive WOULD bring about a reduction in severity	5	0	0	5



This is drawn out in the key points below:

The exemplars relate to the depth of analysis of CSPs, SDPs and contributing factors, and involvement of family in the 29127 report into the AWOL/attempted abduction.

Most reports included lengthy timelines and historical detail, with less analysis and synthesis. The evidence of family involvement in the investigation was at times minimal, and there is little record of feedback to families after investigations. The Trust reported that strong effort was always made to include the family in the review process but often this was declined until the findings were available.

Recommendation 12– The Trust should alter the reporting practice to record the detail of efforts to involve the family in the investigation.

The severity of the incident and level of the investigation are not indicated in the report template.

Root causes are not identified in seven of the reports, and the one that did identified the root cause as the fact that the patient was not transferred out as requested. The review team consider this to be a contributory factor rather than a root cause. There is no demonstrable reduction in frequency and severity in relation to the SIs, until towards the end of 2013. This also suggests that contributory factors and root causes were not identified and remedial actions put in place.

Areas for improvement are in defining the level of report, executive summary content, family involvement, chronology and analysis.

Recommendation 13. The Trust and the CCG should review the report templates, training and Assistant Directors checklist to ensure compliance with the NPSA credibility and thoroughness tools.

3.4.6 SI policy and processes

According to the Trust policy (section 5, page 8), decisions about whether an incident is to be classed as an SI and registered on STEIS are made at Assistant Director level, and allocation of investigation of reports is decided. It is not clear within the policy or practice at what point the *level of severity,* or *level of investigation* is decided. The template reports do not contain a section to record these explicitly. The guidance for severity level uses the *'risk scoring= consequence x likelihood model',* which is a tool to support calculating risk of occurrence and severity, but does not translate easily as a tool to assess the severity level of an incident that has already occurred.

The review noted in the policy the never events listed as applicable to mental health were '*suicide using non-collapsible rails*' and '*escape of a transferred prisoner'.*

The 2013/2014 mental health never events are detailed as:

- death or severe harm to a mental health inpatient as result of a suicide attempt using non-collapsible curtain or shower rails, and
- a patient who is a transferred prisoner escaping from medium or high secure mental health services where they have been placed for treatment subject to Ministry of Justice restriction directions.

The review team suggest reviewing the never events list within the Trust policy, taking the opportunity to incorporate the 2013/2014 revision[16], and incorporating other relevant healthcare events such as entrapment in bedrails, harm from medications and falls from unrestricted windows. Risk and likelihood of occurrence could then be calculated and audited.

[16] *The Never Events list 2013/14 update http://www.england.nhs.uk/wp-content/uploads/2013/12/nev-ev-list-1314-clar.pdf*

There is a clear description of structures for the monitoring of action plans and disseminating organisational learning. The team saw evidence of this used in practice.

A Training Needs Analysis is in place, and there are systems described for educating staff in the application of this procedure.

Areas of Good practice

The review team identified some areas of good practice in the SI process.

There is an internal system for monitoring the quality and timeliness of reports, and a robust process for monitoring the implementation of the action plans.

There are structures for the monitoring of action plans and for disseminating organisational learning.

The OLF provides a rich level of detail about learning from SIs that is cascaded widely.

There is a clear structure that ensures that lessons learned are incorporated into training programmes.

Table 1: Serious Incident timings

STEIS number	Date of SI	Report due – 12 weeks	Interim report	Final report	completed action plan submitted	Final on time	weeks taken to complete interim report	weeks taken to complete final report	Weeks over target	Action plan complete and signed off by NLCCG
2013.10414	8/4/13	1/7/13	27/12/13	6/3/14	6/3/14	no	17	44	32	March 2014
2013.15660	26/5/13	12/8/13	15/8/13	26/11/13	26/11/13	no	12	24	12	Dec 2013
2013.20499	12/7/13	3/10/13	13/9/13	4/12/13	21/2/14	no	4	20	8	April 2014
2013.28957	2/10/13	25/12/13	3/12/13		7/7/14	n/a	11	11		July 2014
2013.29127	2/10/13	25/12/13	4/12/13	pending	pending	yes	11	n/a		Action plan not completed
2013.34699	23/11/13	23/2/14	24/2/14	pending	pending	n/a	12	n/a		Await coroner and action plan sign off
2013.36044	30/11/13	28/2/14	5/2/14	pending	pending	n/a	11	n/a		Await coroner and action plan sign off
2013.37283	17/12/13	17/3/14	18/2/14		7/7/14	yes	9	9		July 2014

The review has tracked the report deadlines and timings above**.** While the interim reports were submitted on time or earlier in all but one case, there is wide variation in the timings of the final reports. Some reports do not have a final report submitted yet (10 months later), and would be supplied to North Lincs CCG for sign off only after the action plan is complete. It was reported that the Trust begin to implement actions as soon as they are identified, and they issue an interim report to the CCG. However, the Trust, in agreement with the CCG has waited until coroners inquests have been held before issuing a final report. It is the review team's view that it is not necessary to establish a cause of death before a final report is issued. Whilst it is acknowledged that the Trust would not wait for the final report before taking action, it is more difficult to track lessons learnt from a draft or interim report, and therefore the final report should be issued as soon as possible.

The Serious Incident Framework[17] is under consultation and the Trust have responded to this.

Recommendation 14. The Trust should not wait for coroner's inquest to produce a final report unless it is clear that the cause of death is material to the lessons to be learnt. The Trust should also ensure that timeliness of reports and action plan completion should be incorporated into the quality assurance process.

Recommendation 15. Review of the joint SI processes with NLCCG and the Trust and ensure compliance with NHS England Serious Incident Framework.

[17] *NHS Commissioning Board Serious Incident Framework 2013 http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf*

3.5 Management and assurance systems

The Trusts systems have been examined as part of this review. This includes the policy framework around:

- risk management
- serious untoward incidents
- clinical risk assessment
- mandatory training
- clinical audit, and
- the governance structure for oversight of these processes and systems.

The team also reviewed the timeline and considered:

- changes (or handovers) in the management of the team or service
- staffing issues (such as sickness or morale)
- quality of care issues
- use of management information, and
- management intervention and external (to the team) assurance or monitoring.

These were developed into a timeline (separate XL spreadsheet which is too large to include as an appendix) which identified opportunities for intervention. In the corner of some cells is a red mark. This identifies that the occurrence should have been seen as a red flag by someone within the management or quality structure. Red flags are referred to (in safety terms) as markers or points in time where someone should have noticed a problem or potential problem and taken action.[18] These include the Trusts current system of 3 complaints or serious incidents in one team being cause for concern.

3.5.1 Review of management actions

The review team started their 'look back' from April 2011, as this was a period of time that people frequently referred to in interviews. At this time the Trust had significantly increased in size after taking on CAMHS and physical health services under the Transforming Community Services programme. The mental health subgroup of North Lincolnshire Local Involvement Network (LInK) commissioned a qualitative review of patients and carers experiences at Great Oaks in 2011, following some negative feedback. The subsequent presentation of the 'who cares' report in April 2011 had raised issues and concerns about the operation of the in-patient units at Great Oaks. Action was taken to change the ward leadership and at the same time the adult service was reconfigured to reflect changes in the care pathways for adults and for older people. In June 2011 the CQC visited the wards, declared compliance and made only minor recommendations. This may have assured the Board and senior managers that care was not unsafe. Elsewhere in the Trust however, the CQC had raised a major concern with the Doncaster adult's mental health service. Of the five standards inspected, only two were compliant with two further minor concerns being raised as well. This context may have led senior management to prioritise Doncaster and let the planned changes at Great Oaks take place, believing that operational management would ensure that the implementation plan resolved the issues raised. Interviewees confirmed that this may have been the case when put to them.

[18] *Reynard J; Reynolds J, Stevenson P (2009) Practical Patient Safety Oxford University Press*

The changes were implemented; the two wards at Great Oaks (Sycamore and Willow) were closed and the staff moved to one new adult ward (Mulberry). A new ward manager (#2) was to be appointed and an action plan implemented to address a number of issues including record-keeping, care planning, named nurse responsibilities and clinical audit. This action plan focused on improving the nursing practice and leadership on the ward. It is pertinent to note that of the 8 recommendations none were focused on or requiring change in medical practice.

The key opportunities for management actions are set out below. It is important to note that these opportunities are identified with the benefit of hindsight, with the knowledge of new ideas and practices and the events that occurred. The purpose of highlighting these points in time is to consider current systems and processes and to determine if these issues would be identified in the Trust today. The review team have used the evidence gathered in interviews and the evidence submitted through documents to establish the findings below.

October 2011. Six months after the 'Who Cares' report, there was 1 serious incident in August and 3 complaints in the month of September. If this had occurred today it would have raised an alert through the Trusts 'smoke detector system' and put the unit under closer monitoring and scrutiny.

At that time a new ward manager #2 commenced in post. This was an opportunity for a fresh pair of eyes on the in-patient area, and for other issues that the 'who cares' action plan had not addressed to be raised by the new ward manager and resolved. It is not clear whether issues were raised or the extent and nature of support or monitoring in place for ward manager #2.

May 2012. Between April - May 2012 the ward had 2 serious incidents and one complaint. The current 'smoke detectors system' would again have put Mulberry under closer monitoring. However it is suggested that the Trust may have taken assurance from two site visits where problems were not identified or raised. There was a site visit from the Deputy Director of Nursing which suggested that care was satisfactory, and a NED visit that reported a positive visit with no safety or care issues being raised. The fact that there were 3 points of concern from SIs and complaints could have prompted a more detailed investigation to get proper assurance on quality at the point of care.

July 2012. In June 2012 there were 2 more complaints and another in July. It appears that over the course of the 6 months that ward manager #2 was in post there had been 8 incidents/complaints. In addition the incidents/complaints about mulberry had not reduced compared to the previous 6 months.

December 2012. There were no incidents/complaints in August or September 2012, but between October and November there were 3 more complaints and a serious incident. In addition an Assistant Director (AD1) in another part of the service raised concerns about how Mulberry was operating with the Assistant Director (AD2) who was responsible for Mulberry. The concerns centred on the culture on the ward, leadership and medical practice. It is not clear what action was taken, the review team did not speak to AD2 as they had left the Trust. Given that there were senior managers concerns, and three complaints and an SI it would have been reasonable to expect some kind of review/investigation. It is clear from the evidence gathered that a need had been identified to review the governance structures and the composition of the leadership team.

March 2013. 'Who cares' conducted a follow up report in February 2013 to Mulberry ward and reported very positively on changes to the environment and what they observed to be positive patient care. However there were still a number and range of negative comments from patients and carers about the ward. This is acknowledged by the Trust in a formal letter confirming discussions and changes would continue. This would have been an opportunity to review all aspects of the plan so far, to look at the evidence of changes being implemented and ensure that all factors had been taken into account. A look back at care evidence since they started the 'who cares' action plan might have raised concerns about the number of SIs and complaints that were still occurring. This could have been a catalyst for more focused, stringent action to improve care.

From May 2013 incremental changes have been made to enable better patient care but no real tangible changes were seen until January 2014 when police calls and SIs stopped, and complaints started to reduce.

It appears that the new leadership and practice support put in place has made a significant difference to patients' safety and how the ward is managed on a day-to-day basis. The problem that the ward and senior leadership now has is to ensure that equivalent changes are made to therapy and treatment, and to the record keeping practice on the ward. Record –keeping and care planning/clinical risk assessment have been identified as key areas that need improvement in all of the SI reports the review has looked at.

The reasons for the slow progress in improving practice on the ward could be attributed to the changes in the ward leadership. The changes that occurred in summer of 2013 will have had an impact, and additional further changes have also been implemented.

During the summer of 2014 the ward team has had some stable leadership and has been able to commence the process of team development that is required. This stability is likely to be upset as the ward manager post will be appointed to substantively during November. New or absent ward leadership is frequently seen as a contributory factor in incidents, and is often a leading indicator for other Trusts early warning systems similar to the RDASH 'smoke detector'. Because of this extra care should be taken to ensure the progress the team has already made is sustained.

Recommendation 16. The Trust should ensure that focused and supportive action is in place to enable the ward team to continue with the improvements they have made, whilst a new ward manager is recruited and inducted.

The review team have compiled a timeline of events using information arising from the documents submitted and the interviews. However it is recognised that this timeline cannot capture everything that was happening in the Trust that could have had an impact. The Trust Executive Team could review the timeline, adding material occurrences, and use it to determine if there are any further learning opportunities. Using a tool such as the 5 whys[19], recommended by the NPSA and the NHS Institute, may help in this process.

[19] *http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/identifying_problems_-_root_cause_analysis_using5_whys.html*

In summary, there were points in time over the past 2-3 years where it was clear that adult in-patient care needed to be improved. Management action was taken, however it did not start to have a material effect until January 2014.

Recommendation 17– The Trust should undertake a 5 whys review of the management and leadership of Adult in-patient care between 2011- 2013.

Assurance systems

A key finding of this review is that the systems and processes for each key stream of work to deliver good quality services appear to be in place and adequate. Looking at the reports available and reflecting on the interviews they appear to have been viewed in isolation until the development of the 'smoke detectors'. During the interviews and discussion that were held people often referred to the smoke detectors system, which identifies if a ward or team has had 3 or more concerning occurrences, and the review team could see that a significant amount of work had been done to develop the smoke detectors, and the system is still under development. The review team saw a list of possible occurrences but the smoke detectors report was not clearly identified as such in any of the quality improvement reports seen. This would make it difficult for board members to review them and determine if something they had picked up through soft intelligence was concerning.

The smoke detector system uses lagging indicators as 'red flags'. 'Lagging indicators' is the term used in industrial settings to define measures that are made after an incident or event has occurred and which assess different types of outcome. These are the reactive measures of an organisation's or system's safety performance. Examples of lagging indicators include lost time, injury rates, incident reporting and incident investigation times.

In contrast, leading indicators broadly focus on identifying precursors, conditions, events or measures before an incident or event has occurred and which might predict whether an event will occur. Leading indicators involve forms of active monitoring of key control systems or 'activity' indicators that show if the organisation is taking actions believed to lower risk. The essence of leading indicators is that they are proactive and measure variables that are believed to be indicators or precursors of safety performance so that safety is achieved and maintained.[20]

As knowledge and understanding around patient safety develops, new concepts are being tested out and the recent research referred to above sets out a new model for measuring patient safety. The review team applied the Health Foundation framework model which sets out the need to measure how safety was, how it is and how it will be. See figure 3 overleaf.

[20] *Burnett J, Carthey S, Vincent C (2013) The measuring and monitoring of safety; Health Foundation London*

Fig 3: Framework for measuring and monitoring patient safety. [21]

The review has identified that whilst the smoke detectors system is an excellent start, it could be further enhanced by adjusting the analysis, and the display of intelligence gained, to show leading indicators. This will help assess how safe care is today and predict how patient care is *likely* to be in the near future.

Leading indicators should cover the quality of inputs to patient care i.e. the quality of staffing (mandatory training figures; sickness absence, supervision compliance) and quality of practice (record keeping, care planning, handover practice, and NICE guideline compliance). Lagging indicators on patient outcomes should also be included as they provide a 'balancing' picture, to confirm that patient care has *not* been adversely affected, this is where monitoring of serious incidents and complaints would come in. It is important that the data is reliable (so testing of data quality should be obtained if it not already assured) and the data needs to be a recent as possible, preferably within 4-6 weeks of occurrence. A sample dashboard is included in Appendix D.

Recommendation 18. The Trust should continue to improve the smoke detector system, include leading indicators and use it to report on the quality at the point of care for each ward or team.

It would also be beneficial if a 'quality surveillance' meeting was established by the Board with the sole purpose of reviewing the intelligence and insight gained by the smoke detectors system, and with the authority to escalate performance concerns about a specific team directly to a board Committee. It is acknowledged that the Performance and Assurance Group review quality performance, but the review believed that the work of the group is determined by exceptions and it may not have time in meetings to fully investigate each team's safety status.

[21] *A framework for measuring and monitoring patient safety- a practical guide (2014) Health Foundation; London*

The quality surveillance meeting would report to the Committee that it has met each month and give a summary of areas reviewed and recommendations made to Service Directors about improvement. Suggested terms of reference are included in Appendix C, and this could be a sub-group of either the Clinical Governance Group or Performance and Assurance Group. To ensure that partners are assured about the quality surveillance process it would be useful to include their representatives in the meeting.

Recommendation 19. The Trust should establish a mechanism (for example a quality surveillance group) for discussing and agreeing action regarding quality at the point of care, consider including external partners in this group- for example patient representatives, the local authority and health commissioners.

3.5.2 Board monitoring and assurance

Board member interviews and a review of the papers from meetings (such as agenda, minutes and action logs) identified that quality is discussed on a regular and frequent basis, and there is a sound quality governance process in place. Board members make visits frequently to service areas as part of their roles, both in terms of engagement with services and stakeholders, but also in their duties as hospital managers under the Mental Health Act. The review team reviewed board reports of the visits and also looked at the signing in sheets for Great Oaks and found evidence that Board members had made visits. The systems and focus in reports at Board recognise quality as being important.

The review found that the reports that are received by Board do not always provide a clear view of quality or safety in every area. Many of the reports are aggregated and can provide some false assurance that quality inputs are in place, for example the training reports often refer to Adult Mental Health as a whole, rather than by team. The Quality Improvement Report contains a large amount of information by theme, such as SIs, complaints etc. It is almost too informative, in that it is difficult to get a summative picture of what care is like at a specific point in time. For example from the Board reports Board members would not have been informed that complaints about Mulberry in 2013/14 amounted to 10% of all Trust complaints.

The Trust is planning to develop individual dashboards on Qlikview (the Trusts electronic performance reporting system), as it is recognised that reporting needs improvement in this way. Developing the smoke detector system so that a report on quality at the point of care (such as a ward or team) is made each month will enhance the Boards understanding of how successful the quality improvement plans are. This will provide hard evidence or sound assurance (as long as the data quality is good) to support the practice and reporting of site visits (part of assessing how safety is today – see figure above). Ongoing monthly, real time, granular reporting of team's performance through the smoke detectors system will provide retrospective validation for a positive site visit, or provide an area to focus attention on in advance of a site visit.

Recommendation 20. The Trust should ensure that the Board is briefed as a whole on quality at the point of care (such as a ward or team) each month.

4. RECOMMENDATIONS

The recommendations are set out below. They have been grouped into improvement areas.

On the ward

Recommendation 2.
The Trust should ensure that the ligature point risk assessment is reviewed.
Recommendation 3.
The Trust should focus on rapid improvement of record-keeping, and improving the depth and quality of written risk assessment and care plans.
Recommendation 4.
The Trust and the CCG should work together to improve the psychology input and the number of therapeutic activity sessions offered on the ward. Validate the impact of the improvements through patient feedback.
Recommendation 16.
The Trust should ensure that focused and supportive action is in place to enable the ward team to continue with the improvements they have made, whilst a new ward manager is recruited and inducted.

On the serious incident investigation process

Recommendation 5.
The Trust should ensure that management action relating to staff performance is reflected appropriately in the SI action plan monitoring process to ensure that tracking of actions and learning lessons is clear
Recommendation 6.
The Trust should revisit the training that investigators have to ensure that root cause analysis is correctly covered and ensure that the policy/process for serious incidents describes a root cause correctly and how to identify it.
Recommendation 7.
The Trust should ensure that the Assistant Directors checklist is completed and used to assure the quality of reports.
Recommendation 12.
The Trust should alter the reporting practice to record the detail of efforts to involve the family in the investigation.
Recommendation 13.
The Trust and the CCG should review the report templates, training and Assistant Directors checklist to ensure compliance with the NPSA credibility and thoroughness tools.
Recommendation 14.
The Trust should not wait for coroner's inquest to produce a final report unless it is clear that the cause of death is material to the lessons to be learnt. The Trust should also ensure that timeliness of reports and action plan completion should be incorporated into the quality assurance process.
Recommendation 15.
Review of the joint SI processes with NLCCG and ensure compliance with NHS England Serious Incident Framework.

On suicide prevention

Recommendation 8.
The Trust and CCG should support the campaign to put suicide prevention interventions at the Humber Bridge.
Recommendation 9.
The Trust should review the clinical risk management/suicide prevention policy to include the risk factors for men.
Recommendation 10.
The Trust training needs analysis should be reviewed to include training on suicide prevention. The suicide prevention policy should then be amended to reflect the needs analysis.

On section 17 leave

Recommendation 11.
The Trust should review the leave policy and include clear responsibilities for decision making and recording by doctors and nurses in charge, with an agreed set of risks to be assessed which include static and dynamic factors. Skills-based training in the application of this policy should be should be made available.

Governance and assurance

Recommendation 1.
The Trust should investigate to understand the reasons for the activity shown in figure 1 (aggressive and disruptive incidents) above.
Recommendation 17.
The Trust should undertake a 5 whys review of the management and leadership of Adult in-patient care between 2011- 2013.
Recommendation 18.
The Trust should continue to improve the smoke detector system, include leading indicators and use it to report on the quality at the point of care for each ward or team.
Recommendation 19.
The Trust should establish a mechanism (for example a quality surveillance group) for discussing and agreeing action regarding quality at the point of care, consider including external partners in this group- for example patient representatives, the local authority and health commissioners.
Recommendation 20.
The Trust should ensure that the Board is briefed as a whole on quality at the point of care each month.

5. CONCLUSION

The review concludes that there is no evidence that patient care on Mulberry ward is unsafe and safety has improved significantly since the summer of 2013. There are sound governance systems in place and the evidence demonstrates that the incidence of patient safety issues has reduced. With regard to concerns raised by external partners; the police feel that the Trust has made significant efforts to improve the circumstances on the ward, that relationships had improved and there was much more opportunity to discuss and develop strategies for working. In addition they reported that there was much less support required from the local police officers. There were also positive indications from the Local Authority that they were working better together.

This review has also established that there were reasons to be concerned about the care being delivered on Mulberry prior to the summer of 2013.

It has found that although the Trust took action in 2011 after a negative report from the local involvement network, and continued to make changes to the governance processes and leadership of the adult in patient team, the changes did not begin to have the right impact until summer of 2013/14. It has been recommended that the Trust should undertake a further review of this in terms of conducting a '5 whys' process.

The benchmarking review established that compared to other Trusts the Trusts performance is relatively good and the staff survey is positive overall.

It is however noted that there are higher levels of reporting in relation to disruptive and aggressive behaviour and it is recommended that the organisation looks at this further.

The key recommendations that will drive improvements focus on:

- Record keeping
- Care planning
- Improve the psychology input for the patients
- Further development of the SI processes
- Continued focus on leadership development

The review established that quality is discussed on a regular and frequent basis, and there is a sound quality governance process in place. The systems and focus in reports at Board recognise quality as being important, and board members visit Great Oaks on a regular basis. Whilst there are improvements needed to the Serious Incident investigation process there are also areas of good practice that the Trust can build on.

There are a number of recommendations that the review team have made which are aimed at improving the quality of patient care, either directly or indirectly. The team have made significant headway in raising the standards of care on the ward, but there is still quite a lot to do.

APPENDIX A:

DOCUMENT LIST

Appendix A - Document List

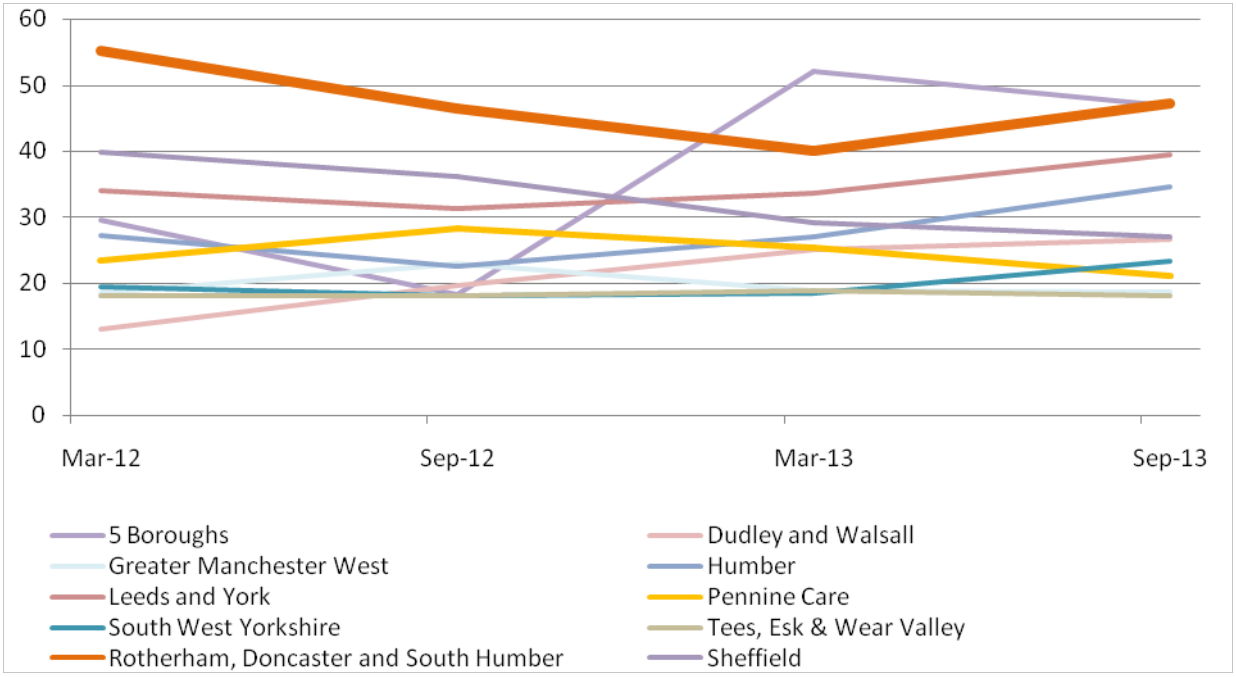
1. Inpatient Staffing Acuity and Dependency Profiles – Clinical Staffing Group Review.
2. Procedure for the Control of Access to the Acute Adult Inpatient Wards.
3. Aide Memoir – Training Needs Analysis.
4. Infection Prevention & Control Audit Tool.
5. Average Monthly Caseload.
6. Patients who are missing or absent without leave (AWOL) Policy.
7. Rotherham Doncaster and South Humber NHS Foundation Trust – Ligature Point Audit Form.
8. Breakdown by Team for Adults Mulberry – Risk Assessment.
9. Rotherham Doncaster and South Humber NHS Foundation Trust - CCG Terms of Reference.
10. Clinical record keeping - Adult Mental Health Inpatient Services, Standard Operating Procedure - Rotherham Doncaster and South Humber NHS FT.
11. Clinical Risk Assessment and Management – Document Control – Rotherham Doncaster & South Humber NHS FT.
12. Great Oaks Training Report 1 April 2011 - 31 March 2014.
13. Mandatory Risk Management Training Policy – Training Needs Analysis.
14. Alignment of Corporate and Adult Business Division Strategic Priorities.
15. Care Programme Approach Policy.
16. Formal Complaints list Adult Mental Health Inpatient North Lincolnshire (email).
17. RDASH Documentation – re-group Supervision provided to staff at Great Oaks.
18. RDASH Document (email) re psychology input.
19. Clinical Audit Programme 2013/14 – Health Records Re-Audit, Quarter 4, 2013/14.
20. Mental Health Community Survey July 2014 – Rotherham Doncaster and South Humber NHS FT.
21. Mental Health Community Survey July 2014 Final Report – Rotherham, Doncaster and South Humber Mental health NHS FT.
22. Ligature Point Audit Form 2013 – Mulberry House HICU.
23. NHS Absence Timeline Analysis – Monthly Absence Rate on 08 Oct 2014 - Mulberry Sickness.
24. Niche Information for D Graham – Staffing Establishments, Brodsworth Ward/Mulberry Ward.
25. Niche Interview notes– Great Oaks, Ashby, Scunthorpe, 11 & 12 September 2014.
26. Document – Standard Operating Procedure for non-Care Programme Approach (CPA) for people accessing specialist mental health services.
27. North Lincolnshire s17 Audit Q4 February 2014.
28. North Lincolnshire s17 Audit Q4 February 2012.
29. North Lincolnshire s17 Audit Q2 September 2013.
30. Obs Report of all action plans V2 – Audit of the policy for the care of Inpatients who are identified as posing a significant risk to themselves or others.
31. PDR Form (Personal & Performance Development Review).
32. Quarterly Quality Improvement Report Executive Summary Quarter 1 (April-June 2014/15) Edition 12 July 2014.
33. Quarterly Quality Improvement Report Quarter 1 (April-June 2014/15) Edition 12 July 2014.
34. Quarterly Quality Improvement Report Quarter 3 (October-December 2013/14) Edition 10 Jan 14.
35. Quarterly Quality Improvement Report Quarter 4 (January-March 2013/14) Edition 11 April 2014.
36. Section 17 Audit Report March 2013.
37. Section 17 Leave of Absence Approved MHLC 05.02.14, V8.1 version updated.
38. Policy for the Management of Serious Incidents 22.11.2013 version 13.
39. NHS Patient Safety Thermometer: Dashboard – AMH July 2014.
40. Suicide Prevention Policy October 2011.
41. Supportive-Observation Policy 03.06.14 version 4.
42. Scanned document- signing in list - Great Oaks 201 0556 001.
43. Training Matrix 2012-2015 – Mulberry House Staff.
44. Ward to Board Diagram – August 2014.
45. Joint Agency Protocol for the Implementation of YHIP-Section-136-Protocol-approved-MHLC-6.11.2013-V3.

APPENDIX B:

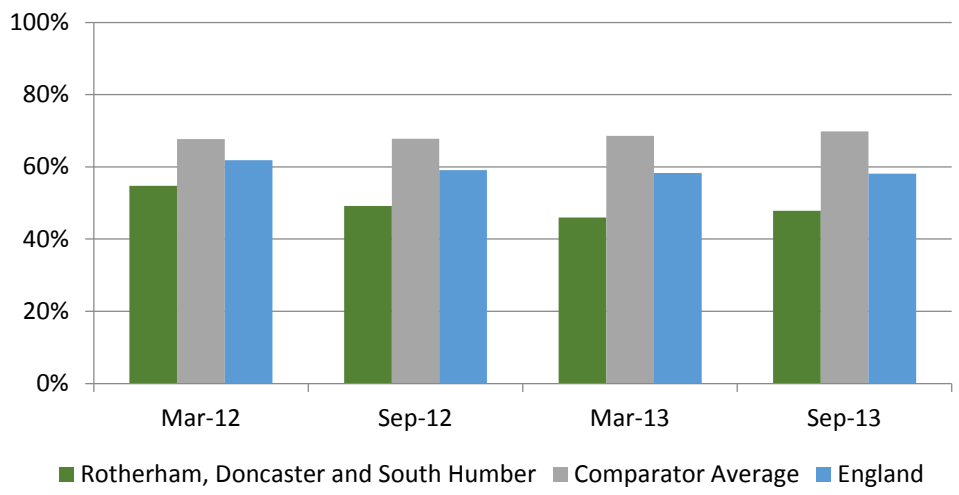
RDASH BENCHMARKING

APPENDIX B – RDASH BENCHMARKING

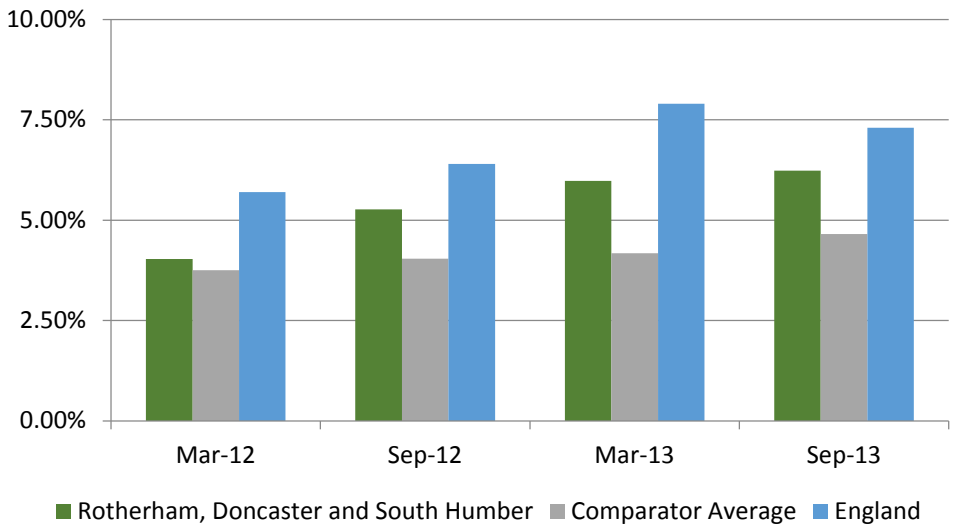
Reporting Rate				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**55.17**	**46.41**	**40.11**	**47.22**
5 Boroughs	29.66	18.23	52.06	46.79
Dudley and Walsall	12.98	19.6	25.01	26.56
Greater Manchester West	18.52	23.03	18.93	18.68
Humber	27.32	22.59	26.96	34.53
Leeds and York	34.1	31.39	33.73	39.47
Pennine Care	23.36	28.22	25.3	21.17
Sheffield	39.83	36.15	29.09	27.07
South West Yorkshire	19.37	18.19	18.55	23.41
Tees, Esk & Wear Valley	18.08	18.07	18.92	18.15



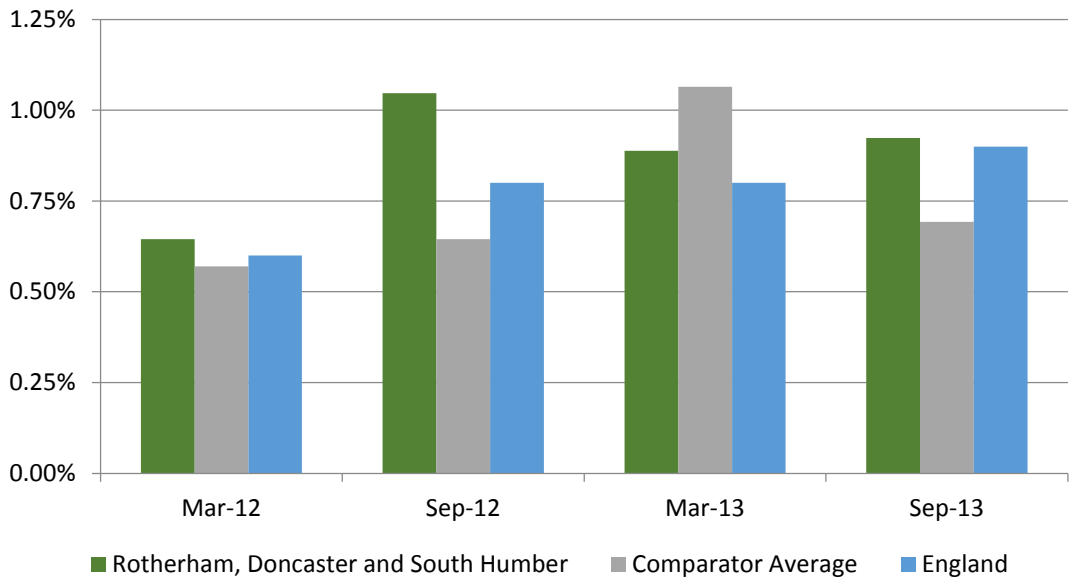
No Harm				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**55%**	**49%**	**46%**	**48%**
5 Boroughs	69%	75%	79%	75%
Dudley and Walsall	48%	45%	49%	50%
Greater Manchester West	63%	68%	60%	56%
Humber	68%	63%	67%	85%
Leeds and York	74%	71%	69%	76%
Pennine Care	54%	51%	48%	52%
Sheffield	0%	12%	79%	78%
South West Yorkshire	65.5%	70%	70%	73%
Tees, Esk & Wear Valley	69.6%	68%	72%	71%
Comparator Average	68%	68%	69%	70%
England	61.8%	59.1%	58.3%	58%



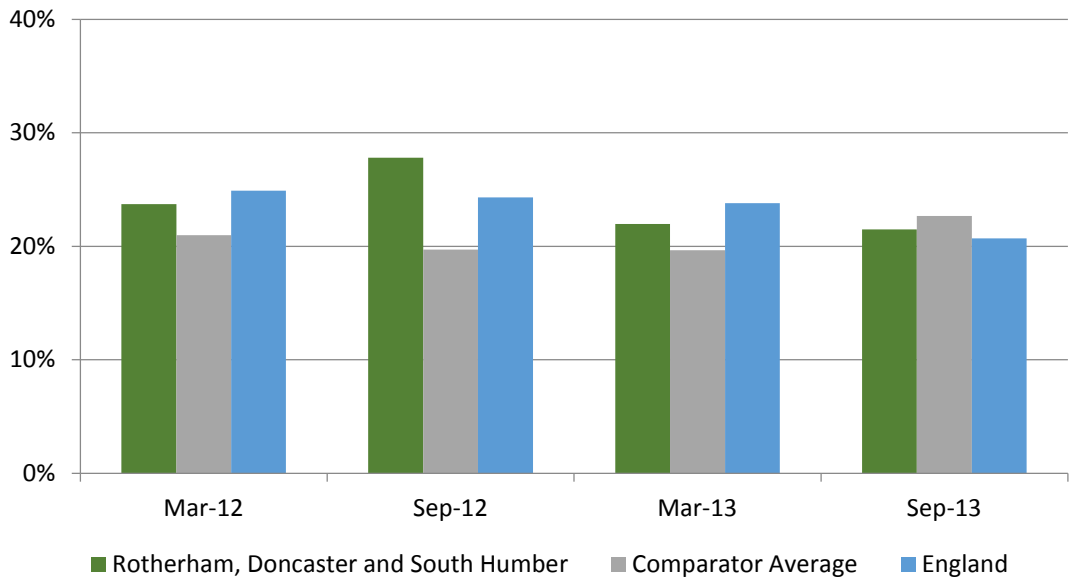
Moderate Harm				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**4.0%**	**5%**	**6%**	**6%**
5 Boroughs	1.2%	1%	1%	4%
Dudley and Walsall	6.6%	9%	9%	6%
Greater Manchester West	7.1%	6%	8%	6%
Humber	4.1%	4%	4%	5%
Leeds and York	2.3%	3%	4%	1%
Pennine Care	7.9%	7%	5%	7%
Sheffield	4.7%	6%	4%	2%
South West Yorkshire	6.3%	6%	5%	6%
Tees, Esk & Wear Valley	4.1%	4%	5%	6%
Comparator Average	3.8%	4%	4%	5%
England	5.7%	6.4%	7.9%	7%



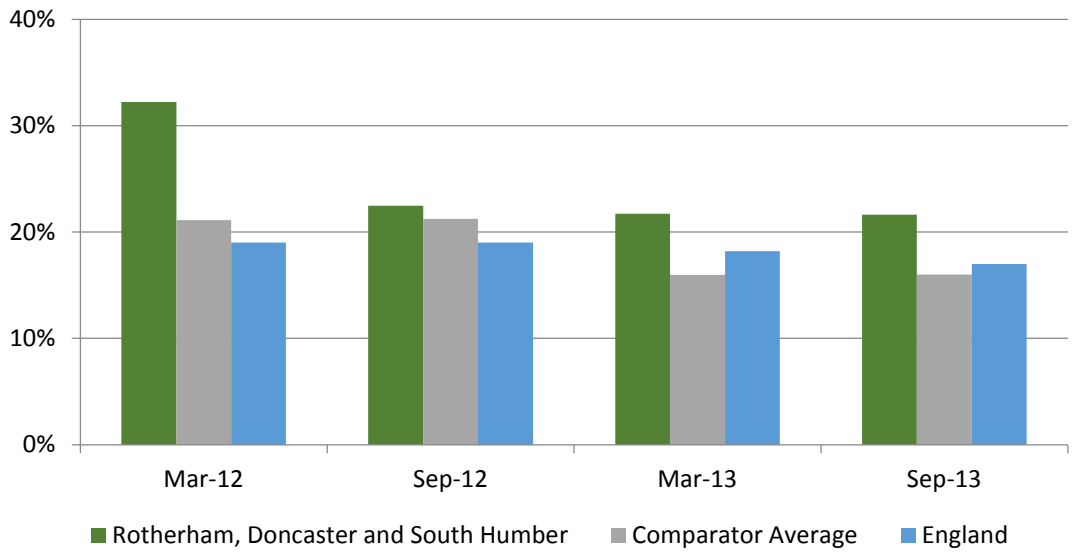
Death				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**0.6%**	**1%**	**1%**	**1%**
5 Boroughs	0.5%	0%	1%	0%
Dudley and Walsall	2.4%	2%	2%	2%
Greater Manchester West	0.2%	1%	1%	2%
Humber	0.7%	1%	1%	0%
Leeds and York	0.5%	0%	1%	0%
Pennine Care	0.6%	1%	1%	1%
Sheffield	1.6%	1%	1%	1%
South West Yorkshire	1%	1%	1%	0%
Tees, Esk & Wear Valley	1%	1%	1%	1%
Comparator Average	0.6%	1%	1%	1%
England	0.6%	0.8%	0.8%	1%



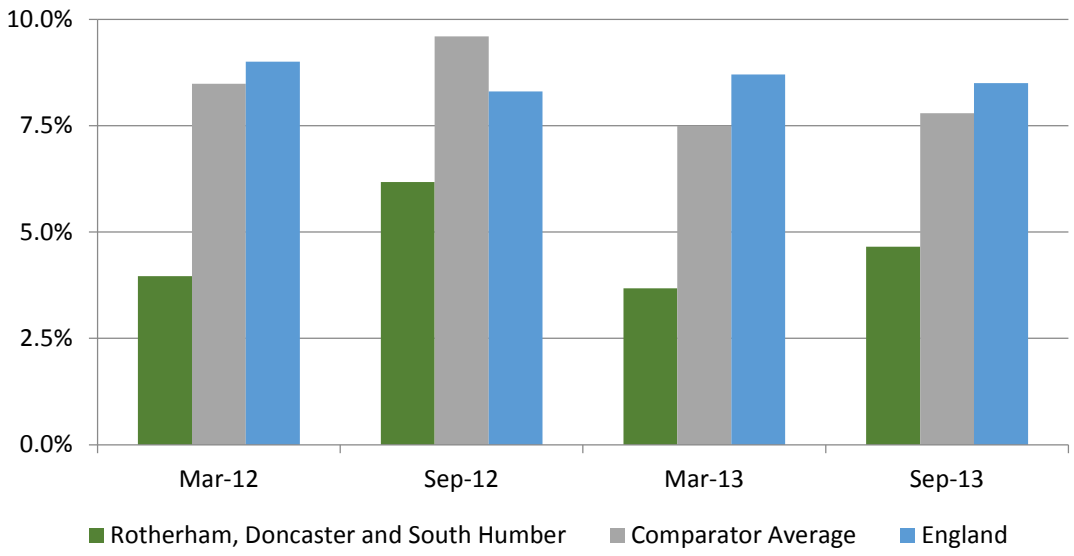
Patient Accident				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**24%**	**28%**	**22%**	**21%**
5 Boroughs	20%	12%	11%	11%
Dudley and Walsall	31%	21%	27%	27%
Greater Manchester West	15%	14%	18%	13%
Humber	16%	17%	11%	12%
Leeds and York	27%	26%	30%	29%
Pennine Care	28%	24%	27%	29%
Sheffield	45%	35%	40%	37%
South West Yorkshire	30%	28%	28%	22%
Tees, Esk & Wear Valley	25%	24%	24%	24%
Comparator Average	21%	20%	20%	23%
England	25%	24%	24%	21%



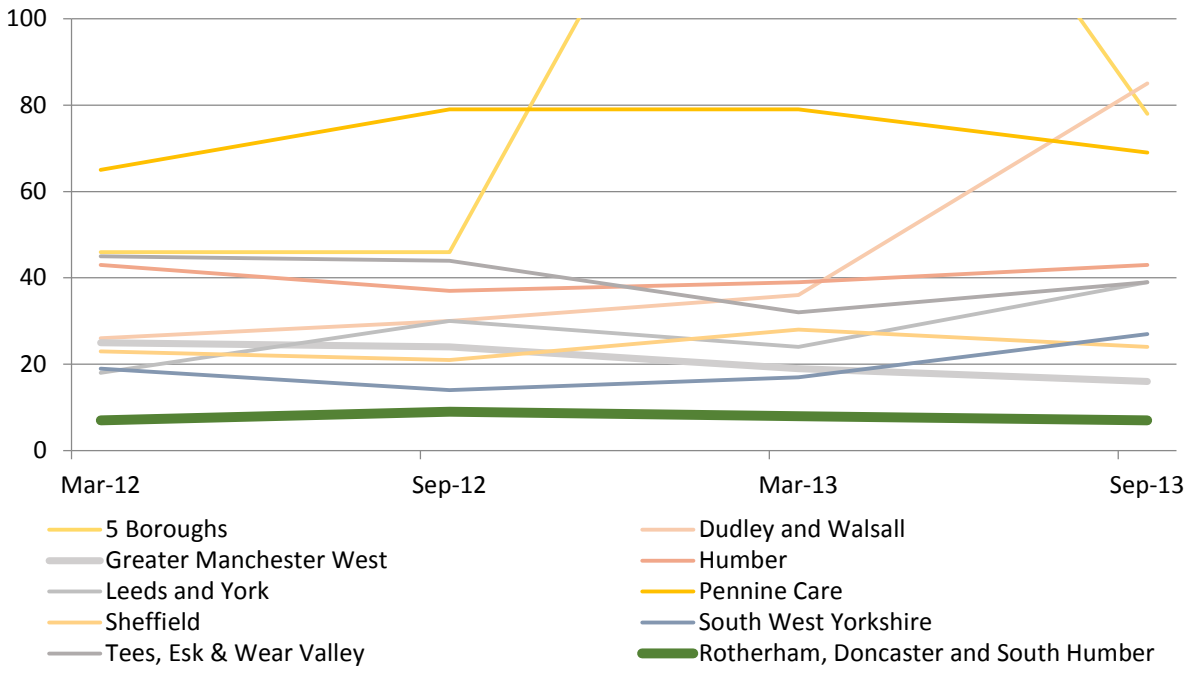
Disruptive Aggressive Behaviour				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**32%**	**22%**	**22%**	**22%**
5 Boroughs	19%	17%	8%	9%
Dudley and Walsall	13%	11%	12%	11%
Greater Manchester West	22%	20%	20%	19%
Humber	21%	21%	17%	16%
Leeds and York	24%	25%	20%	27%
Pennine Care	10%	12%	7%	8%
Sheffield	18%	21%	16%	19%
South West Yorkshire	12%	14%	14%	14%
Tees, Esk & Wear Valley	17%	14%	14%	16%
Comparator Average	21%	21%	16%	16%
England	19%	19%	18%	17%



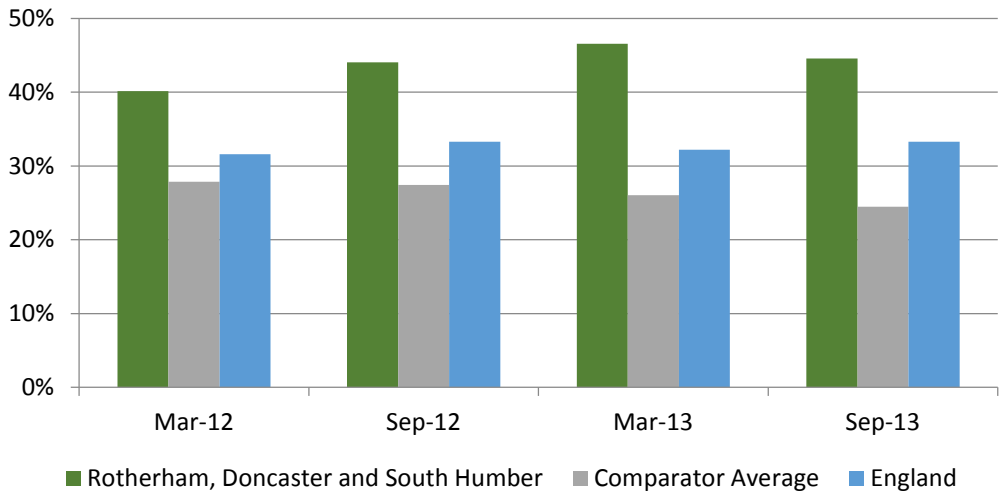
Access, admission, transfer, discharge				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**4%**	**6%**	**4%**	**5%**
5 Boroughs	7%	7%	7%	7%
Dudley and Walsall	10%	7%	8%	9%
Greater Manchester West	13%	14%	11%	13%
Humber	10%	9%	9%	10%
Leeds and York	5%	8%	6%	5%
Pennine Care	7%	9%	8%	7%
Sheffield	7%	7%	5%	5%
South West Yorkshire	6%	7%	8%	8%
Tees, Esk & Wear Valley	8%	7%	6%	8%
Comparator Average	8%	10%	7%	8%
England	9%	8%	9%	9%



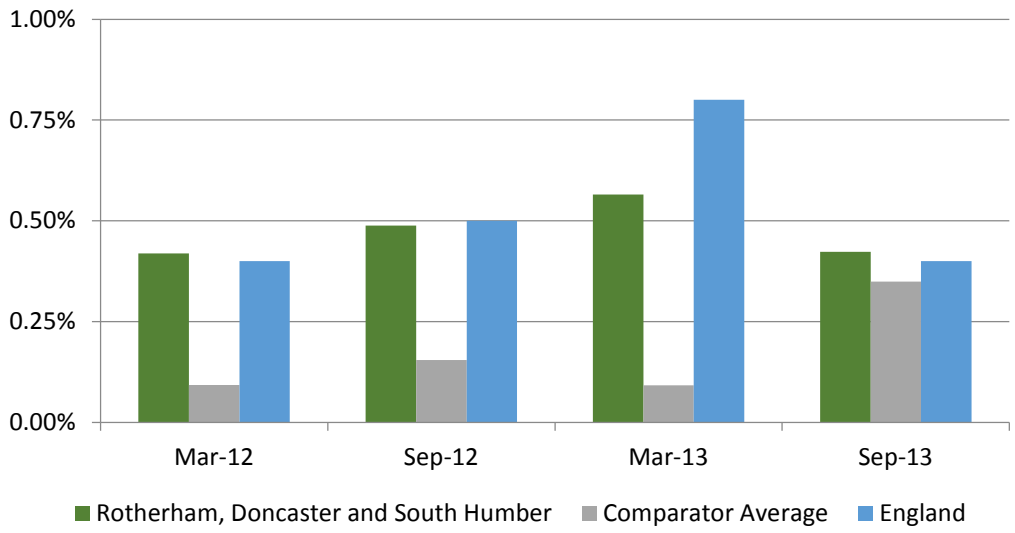
Median Reporting Time				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**7**	**9**	**8**	**7**
5 Boroughs	46	46	192	78
Dudley and Walsall	26	30	36	85
Greater Manchester West	25	24	19	16
Humber	43	37	39	43
Leeds and York	18	30	24	39
Pennine Care	65	79	79	69
Sheffield	23	21	28	24
South West Yorkshire	19	14	17	27
Tees, Esk & Wear Valley	45	44	32	39



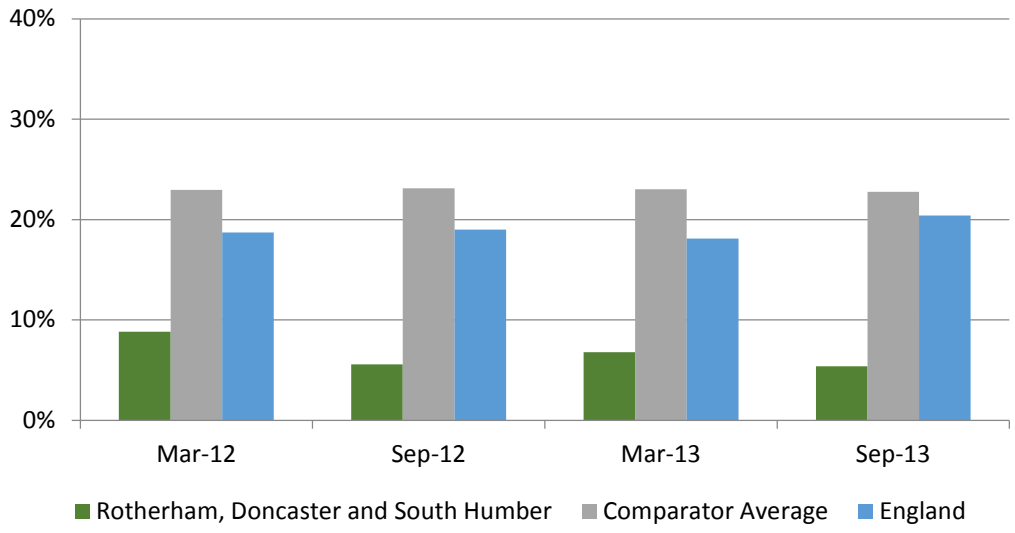
Low Harm				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**40.1%**	**44%**	**47%**	**45%**
5 Boroughs	29.7%	24%	19%	20%
Dudley and Walsall	42.8%	43%	39%	41%
Greater Manchester West	29.7%	25%	31%	36%
Humber	27.2%	32%	28%	9%
Leeds and York	23.0%	26%	25%	23%
Pennine Care	37.2%	41%	46%	41%
Sheffield	93.1%	80%	16%	19%
South West Yorkshire	25.8%	22%	23%	19%
Tees, Esk & Wear Valley	25.7%	26%	22%	22%
Comparator Average	27.9%	27%	26%	25%
England	31.6%	33.3%	32.2%	33%



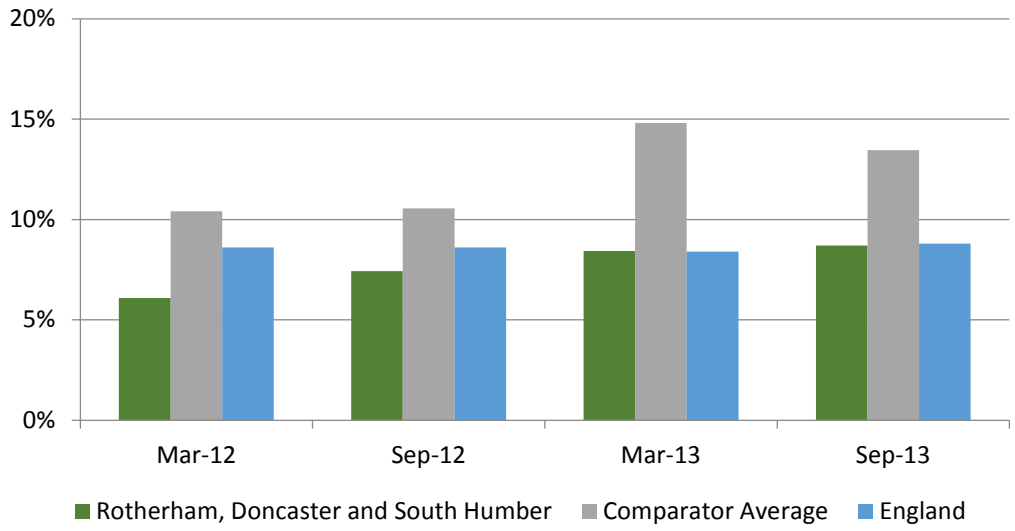
Severe Harm				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**0%**	**0%**	**1%**	**0%**
5 Boroughs	0%	0%	0%	0%
Dudley and Walsall	0%	1%	1%	1%
Greater Manchester West	0%	0%	0%	0%
Humber	0%	0%	0%	1%
Leeds and York	0%	0%	0%	0%
Pennine Care	0%	0%	0%	0%
Sheffield	0%	0%	0%	0%
South West Yorkshire	1%	1%	1%	1%
Tees, Esk & Wear Valley	0%	0%	0%	0%
Comparator Average	0%	0%	0%	0%
England	0.4%	0.5%	0.8%	0%



Self-Harming Behaviour				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**9%**	**6%**	**7%**	**5%**
5 Boroughs	29%	26%	22%	21%
Dudley and Walsall	15%	30%	25%	23%
Greater Manchester West	35%	39%	36%	45%
Humber	11%	13%	21%	13%
Leeds and York	18%	14%	17%	15%
Pennine Care	25%	22%	22%	24%
Sheffield	10%	11%	14%	12%
South West Yorkshire	17%	17%	19%	19%
Tees, Esk & Wear Valley	33%	35%	36%	31%
Comparator Average	23%	23%	23%	23%
England	19%	19%	18%	20%

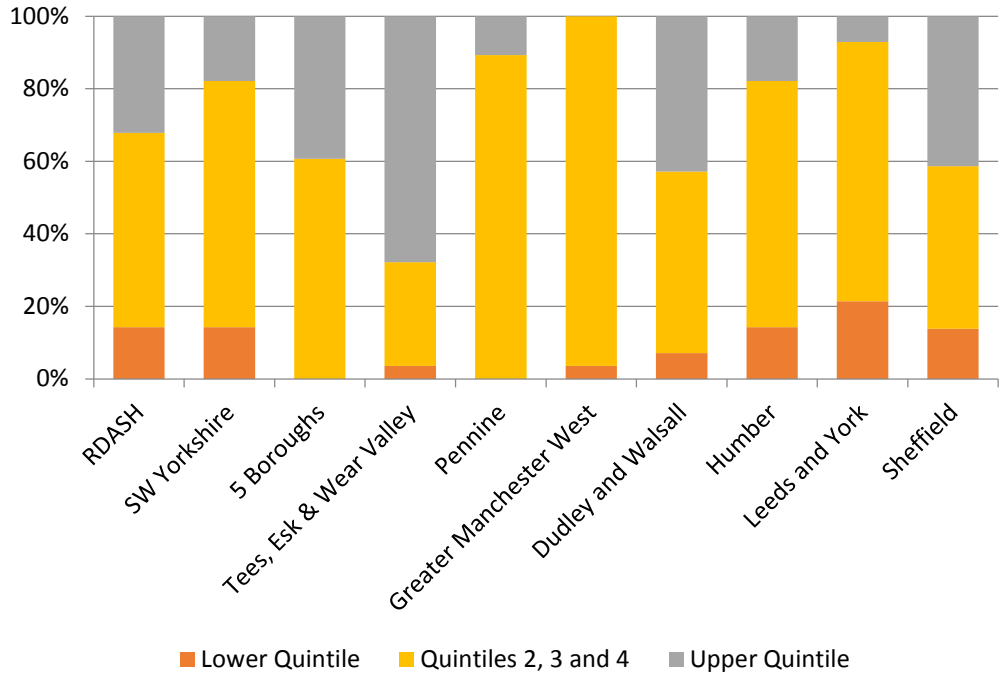


Medication				
Trust	***Mar-12***	***Sep-12***	***Mar-13***	***Sep-13***
Rotherham, Doncaster and South Humber	**6.1%**	**7%**	**8%**	**9%**
5 Boroughs	7.4%	22%	30%	33%
Dudley and Walsall	2.7%	5%	7%	9%
Greater Manchester West	7.2%	6%	7%	6%
Humber	16.5%	12%	8%	9%
Leeds and York	13.0%	11%	11%	10%
Pennine Care	8.1%	8%	8%	9%
Sheffield	6.4%	6%	5%	6%
South West Yorkshire	11.5%	13%	10%	11%
Tees, Esk & Wear Valley	13.1%	14%	17%	17%
Comparator Average	10.4%	11%	15%	13%
England	9%	9%	8%	9%



NHS Staff Survey results

	RDASH	SW Yorkshire	5 Boroughs	Tees, Esk & Wear Valley	Pennine	Greater Manchester West	Dudley and Walsall	Humber	Leeds and York	Sheffield
Lower Quintile	4	4	0	1	0	1	2	4	6	4
Quintiles 2, 3 and 4	15	19	17	8	25	27	14	19	20	13
Upper Quintile	9	5	11	19	3	0	12	5	2	12

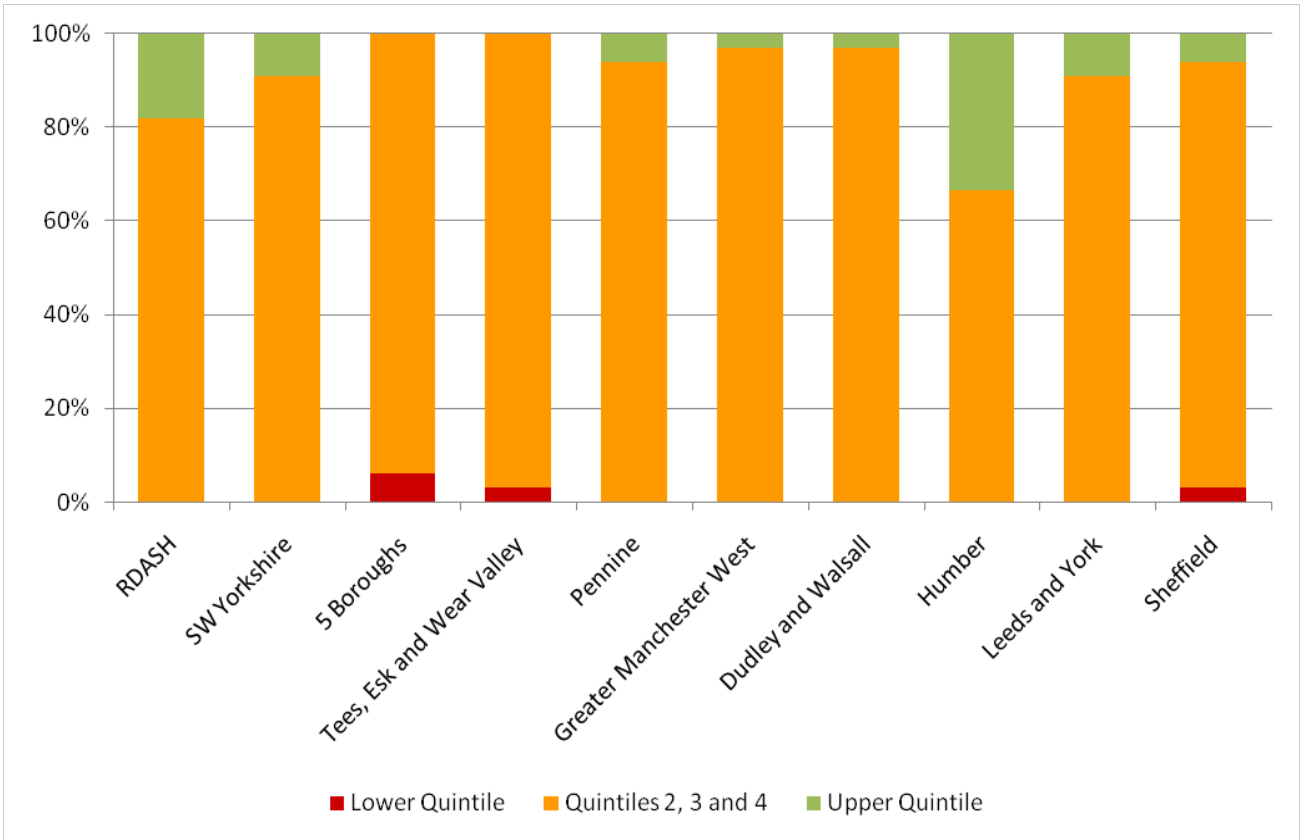


NHS Staff Survey results

	RDASH	SW Yorkshire	5 Boroughs	Tees, Esk & Wear Valley	Pennine	Greater Manchester West	Dudley and Walsall	Humber	Leeds and York	Sheffield	
Key Finding 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver											STAFF PLEDGE 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities
Key Finding 2. Percentage of staff agreeing that their role makes a difference to patients											
Key Finding 3. Work pressure felt by staff											
Key Finding 4. Effective team working											
Key Finding 5. Percentage of staff working extra hours											
Key Finding 6. Percentage of staff receiving job-relevant training, learning or development in last 12 months											STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
Key Finding 7. Percentage of staff appraised in last 12 months											
Key Finding 8. Percentage of staff having well structured appraisals in last 12 months											
Key Finding 9. Support from immediate managers											
Key Finding 10. Percentage of staff receiving health and safety training in last 12 months											STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
Key Finding 11. Percentage of staff suffering work related stress in last 12 months											
Key Finding 12. Percentage of staff saying hand washing materials are always available											
Key Finding 13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month											
Key Finding 14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month											
Key Finding 15. Fairness and effectiveness of procedures for reporting errors, near misses and incidents											
Key Finding 16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months											
Key Finding 17. Percentage of staff experiencing physical violence from staff in last 12 months											
Key Finding 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months											
Key Finding 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months											
Key Finding 20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell											
Key Finding 21. Percentage of staff reporting good communication between senior management and staff											STAFF PLEDGE 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
Key Finding 22. Percentage of staff able to contribute towards improvements at work											
Key Finding 23. Staff job satisfaction											ADDITIONAL THEME: Staff Satisfaction
Key Finding 24. Staff recommendation of the trust as a place to work or receive treatment											
Key Finding 25. Staff motivation at work											
Key Finding 26. Percentage of staff having equality and diversity training in the last 12 months											ADDITIONAL THEME: Equality and Diversity
Key Finding 27. Percentage believing that trust provides equal opportunities for career progression or promotion											
Key Finding 28. Percentage of staff experiencing discrimination at work in the last 12 months											
Overall Engagement Score											

NHS Community Mental Health survey 2014 results

	RDASH	SW Yorkshire	5 Boroughs	Tees, Esk and Wear Valley	Pennine	Greater Manchester West	Dudley and Walsall	Humber	Leeds and York	Sheffield
Lower Quintile	0	0	2	1	0	0	0	0	0	1
Quintiles 2, 3 and 4	27	30	31	32	31	32	32	22	30	30
Upper Quintile	6	3	0	0	2	1	1	11	3	2



APPENDIX C:

DRAFT TERMS OF REFERENCE FOR

QUALITY SURVEILLANCE GROUP

Appendix C - DRAFT TERMS OF REFERENCE QUALITY SURVEILLANCE MEETING

AUTHORITY

The Trust Board has hereby established a meeting to be known as the Quality Surveillance Meeting. The Quality Surveillance Meeting is authorised to investigate anything within the scope of its terms of reference and is required to escalate concerns about quality of care directly to the XXX Committee.

PURPOSE

The purpose of the Quality Surveillance Meeting (QSM) is to systematically bring together the different parts of the organisation to share information. The QSM will be a proactive forum for collaboration, providing:

- a shared view of risks to quality through sharing intelligence;
- an early warning mechanism of risk about poor quality; and
- opportunities to coordinate actions to drive improvement.

OBJECTIVES

The QSM will collectively consider and triangulate information and intelligence to safeguard the quality of care. In particular, the QSM will consider:

- what the data and soft intelligence is indicating about where there might be concerns regarding the quality of services;
- where the QSM is most worried about the quality of services;
- whether further action is required to address concerns, or collect further information; and
- where is there a lack of information and so a need for further consideration and / or information gathering.

SCOPE

The QSM will be primarily concerned with services delivered by RDASH. The QSM does not have executive powers and will not:

- performance manage teams or services;
- interfere with the statutory roles of constituent organisations, e.g. contractual powers or regulatory responsibilities; or
- substitute the need for individual managers to act promptly when pressing concerns become apparent.

MEMBERSHIP

The core membership of the QSM will include the following representatives:
(Chair) Nursing Director and/or Medical Director
Clinical Leads
Local Healthwatch representative(s)
Local Authority representative
Lead for Patient Safety
Lead for Risk and Assurance
Lead for compliance
Lead for Clinical Audit
Lead for Performance
Lead for learning and development
Lead for HR

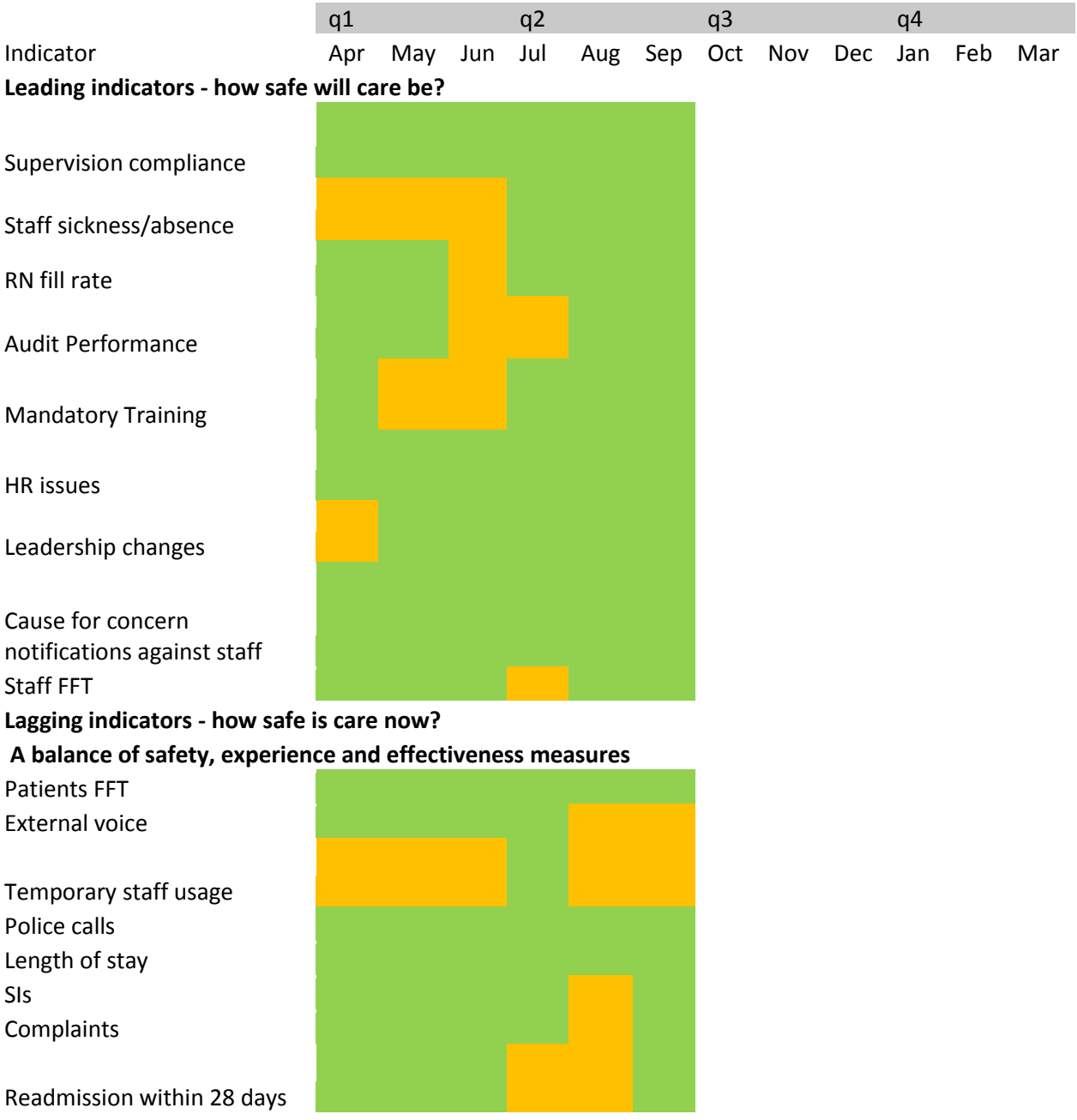
WORKING ARRANGEMENTS

The QSM will meet monthly. The frequency of the meetings will be reviewed annually. The meetings will be recorded and the notes/minutes reported to the XXX Committee meeting.

APPENDIX D:
DRAFT CONTENT FOR SMOKE DETECTOR DASHBOARD

Appendix D – DRAFT CONTENT FOR SMOKE DETECTOR DASHBOARD

Patient Care Dashboard



APPENDIX E:

CONSULTANT PROFILES

Appendix E - CONSULTANT PROFILES

NICK MOOR

RMN, RGN, P.G Cert HSM, MBA, PG Dip Law

Director
Niche Patient Safety

Nick is passionate about patient safety, in particular improving the quality of investigations, and helping organisations learn from incidents and embed changes in clinical and board assurance processes.

He has over 20 years health care experience, the majority of this in mental health. An RMN by background, Nick has thorough understanding of clinical practice and an MBA from Sheffield University.

He is also passionate about patient safety and quality, and set up our patient safety team. He maintains a keen interest in the legal and ethical aspects of healthcare and has a Post Graduate Diploma in Law from Cardiff Law School in this field, and is trained in Root Cause Analysis investigation techniques.

His key skills lie within:

- Quality Governance Reviews and Assurance
- Independent internal investigations and action plans
- Thematic look back analysis of incident reports and action plans
- Independent service reviews
- Coaching and training in conducting RCA investigations
- Clinically focussed risk management and incident reduction
- Setting up risk management reporting structures and evidence portfolios for incident reporting and management

Recent Quality, Patient Safety and Risk Management work:

- Quality Governance Reviews for aspirant Foundation Trusts
- Review of Ward to Board assurance processes for NHS Trust
- Review of clinical and commissioning pathway for governance and safe practice following serious incident
- Understanding commissioner quality assurance needs for NHS Trust
- Lead Director responsible for Homicide investigations under HSG (94) 27
- Independent Investigations after suicides (two separate investigations)
- Developed and project managed Appreciative Inquiry method and Peer Review project to improve risk management in reducing suicide across three mental health trusts
- Reviewed action plan implementation and provided thematic analysis of 35 Action plans for a PCT following a suicide within a mental health Trust
- Director responsible for delivery of independent investigations in acute healthcare including unexpected deaths
- Governance and safety review of practice within a Community Mental Health Team
- Governance and safe practice review of care placement procedures in NHS partnership Trust

CHRISSIE COOKE

RN(LD), RN(Adult) PGDip

Executive Nurse Consultant
Niche Patient Safety

Chrissie has had a long career across mental health, learning disability services & acute care. She is passionate about patient safety and in particular governance systems and processes to help organisations learn and embed changes in clinical practice and organisational culture. She is also a duel registered nurse.

Chrissie has more than 28 years health & social care experience covering a broad variety of practice including mental health and learning disabilities, looked after children and general medicine and general surgery. Chrissie has substantial credentials in governance and quality, including several years' experience as an executive nurse director on both in NHS commissioning and provider boards.

Her career prior to joining us encompasses being:

- Executive director/Executive nurse in a north west PCT
- Programme Manager at a leading mental health Foundation Trust
- Executive Director of Nursing & Midwifery at an acute Trust
- Executive Director of Nursing & Quality at a combined mental health & community Trust

Her key skills lie within:

- independent scrutiny of organisational systems and governance processes
- major ward & community staffing reviews
- Critique of strategy from a clinical perspective
- comprehensive review of progress against quality action plans
- analysis and review of quality performance & practice
- designing and establishing sound governance structures
- policy & strategy development
- coaching and mentoring senior managers
- clinically focussed risk management

Recent mental health work:

- Developed a clinical quality strategy
- Led the review of, and delivered changes to practice in a 'lessons learnt' review
- Led and delivered large scale staffing establishment reviews
- Led and delivered turnaround plan for CQC/MHA compliance

Chrissie is also Chair of Trustees of a charity (Visyon) providing psychological & emotional services to children, young people & adults. She leads the development of strategy & oversees governance & compliance.

CAROL ROONEY

BA, RMN, MSc

Senior Investigations Manager
Niche Patient Safety

Carol is passionate about patient safety, in particular improving the quality of investigations, helping organisations learn from incidents and develop systems to support prevention.

Carol is a Registered Mental Nurse (RMN) of 26 years who has worked in a variety of clinical, managerial and professional lead roles in the NHS and Independent mental health sector, working extensively in Forensic services. She has significant experience of leading on clinical risk management and violence reduction, holding a patient safety role as head of clinical risk management for a national mental health charity. Here she led on all aspects of patient safety improvement including the leadership and management of serious incident investigations and the learning of lessons, complaints and claims.Her previous substantive posts in Forensic Services before joining Niche were as Senior Practice Development Nurse, Head of Clinical Risk Management, and Director of Nursing.

Carol has a keen interest in the development of individuals, services and teams to ensure that they are equipped to meet the needs of patients, ensure positive clinical outcomes and gain satisfaction and pride from what they do. She has a degree in Psychology, a Master's Degree in Health Studies, and is working towards a professional doctorate in the field.

Carol has published on risk management, aggression management training, and trauma support for mental health staff.

Her key skills lie within:

- independent scrutiny of internal investigations and action plans
- independent security reviews
- conducting RCA investigations
- clinically focussed risk management and incident reduction
- aggression management and violence reduction
- clinical risk policy development

Recent Quality, Patient Safety and Risk Management work

- development and implementation of teaching standards and policies in Prevention and Management of Violence and Aggression
- review of risks and protective factors regarding never events in an independent provider
- initiated a falls reduction programme
- self-harm and suicide prevention initiative in a forensic service
- project managed and author of investigation reports for Serious Incident that require investigation (SIRI)
- independent Investigations after suicides (two separate investigations)
- managed a trauma support service for mental health staff
- practice review of security procedures in NHS Foundation Trust Forensic service
- teaching on Degree and Masters courses on aggression reduction and risk management
- leading business continuity management implementation in a forensic service

PAUL HURST

Information Analyst
Niche Patient safety

Paul's background is in economics, having worked previously as an operations analyst in the gambling industry. Paul has now turned his skills towards the analysis and interpretation of information relating to mental health.
He is involved in supporting a wide variety of projects providing analysis. Paul's key skill areas include comparative analysis, database administration and market analysis.

Since working with the company, Paul has had experience in:

- Ongoing analysis and evaluation of the effectiveness of a new child and adolescent mental health home treatment team being trialled by commissioners in Birmingham
- A data-led evaluation the provision of integrated care services in North West London
- Analysis and demand modelling for the implementation of a new acute care liaison team operating in Nottinghamshire
- Analysis of activity data with a view to identifying efficiencies and areas for performance improvement
- Benchmarking of finance, service and performance data to aid high-level strategic commissioning decisions, using national and internal datasets, including their application to the new PCT clusters.
- Calculating the prevalence of mental health disorders and forecasting the likely demand on services
- Collating, analysing and presenting demographic data to help assess current and future demand for services
- Analysis of the current market for mental health services, both within the NHS and the independent sector