Thematic review: briefing for stakeholders

Summary

In March 2016 Sussex Partnership jointly commissioned a thematic review of homicides with NHS England. Following a procurement process, independent organisation Caring Solutions was selected to undertake the review. This examined nine cases where an individual known to Sussex Partnership committed a homicide and one case where the victim was known to services.

The review has now been completed and will be published on Tuesday 18 October 2016.

Background

The aim of the review was to provide an independent assessment of how we have responded to homicides involving people under the care of our services and look at whether there are any common themes we need to respond to.

It was initiated in the light of the care we provided to MD, a patient known to adult mental health services who was found guilty of manslaughter on the grounds of diminished responsibility in July 2016. Prior to the court case, our own serious incident review established that aspects of the care and treatment we provided should have been better. We anticipated that this would result in legitimate public / stakeholder interest in and scrutiny of the quality and safety of our services.

Review process

The terms of reference agreed with NHS England specified that:

- The purpose of the review was to establish whether there are service related themes / wider issues or links recurring across the 10 incidents considered
- The process should focus on emerging themes and not the reinvestigation of individual incidents
- The review should identify whether all learning from these incidents has been identified and all required changes to practice embedded in the organisation.

The review team consisted of a clinical panel supported by two senior associates with expertise in thematic analysis, benchmarking and quality assurance, and a lay carer. All members of the team have experience in independent investigations.

Senior members of the Trust and NHS England have worked with Caring Solutions throughout the review process to support them in producing a report which is clear and accessible and which will help us have an open, constructive conversation with stakeholders about the quality and safety of our services.

Scope of the review

The review examined cases in the last five years where a homicide occurred involving someone known to Sussex Partnership services or where the independent investigation process concluded in this time period. The rationale for this was that it would be difficult to extract and apply new learning from historical cases (i.e longer than five years ago) given that services provided by Sussex Partnership have changed so significantly in recent years.

In this five year period, eight incidents occurred where the perpetrator was known to Sussex Partnership services and one incident where the victim was known. In addition, one of the cases covered by the thematic review dates back to 2007 because the independent investigation process did not conclude until much later**.**

Report findings

Key findings of the review report include:

- The number of homicides involving patients known to Sussex Partnership is not disproportionately high given the size of our catchment area and the number of people we treat. That said, every single incident of this nature is of course a tragedy which has devastating consequences for the families affected
- In a number of cases there were delays either between GP referral and initial assessment by the Trust or between initial assessment by the Trust and access to more specialist assessment e.g forensic services
- In seven out of the nine cases of homicide, there was criticism of the risk assessment process and/or the design of the risk management plan. In several cases, the process was seen as inadequate or the risk posed was not recognised or was seriously underestimated.
- On several occasions in the investigation reports, Trust staff did not know the full extent of their legal powers under the Mental Health Act
- Several investigations reported that staff did not conform to local policies and / or national guidelines on issues such as assessing carers' needs
- The Trust was able to provide evidence that four fifths of the 100 actions identified in individual incident investigations had been implemented
- The Trust has established clear lines of accountability and responsibility for reporting, investigating and learning from homicides and other serious incidents.

An important point which emerges from the review is about what we can do to ensure that recommendations and action plans from internal homicide inquiries focus on outcomes (changing practice) and impact (on stakeholders such as staff, service users and their carers) rather than focusing on process (developing a policy, providing training).

Other factors relating to publication

NHS England has three historic individual independent investigations relating to Sussex Partnership which it plans to publish ahead of the thematic review (because they have covered in Caring's Solution's report). These are:

- An assault by an adult male patient on his father in Scotland in 2012 which led to the death of his mother from pre-existing heart condition
- A follow up independent investigation regarding the murder conviction of a 19 year old male in 2012 who had been known to CAMHS and briefly to adult services
- A follow up independent investigation report to a 2013 incident in when a patient at Langley Green Hospital was responsible for the homicide of another (the victim had absconded, the victim had been given permission to leave the hospital).

All three reports will be published on NHS England's website and signposted in Caring Solution's thematic review report.

Recommendations

Recommendations which the Trust is asked to consider by Caring Solutions can be summarised as follows:

- Monitor the implementation of the CDS structure and the use of the Safeguard Serious Incident recording system to ensure the investigation management and implementation of action plans are consistent with Trust policies, processes and systems
- Provide assurance and evidence that learning from all recommendations is fully embedded across the organisation in a timely manner
- Ensure clinical staff have dedicated time for recording notes and record keeping; that staff record the rationale for the clinical decisions they make; and use risk assessment and formulation to inform relapse planning
- Investigate the feasibility of technological solutions to make it easier to complete records and improve productivity e.g the use of voice recognition technology
- Develop a checklist of key requirements, based on the themes identified in this report, to be used at all CPA reviews
- Evaluate the impact of training and education
- Implement the 'Triangle of Care' approach to involving carers in the care and treatment of service users and achieve membership of the national programme within 12 month.

Our response

Publication

Our objectives in publishing the report are to:

- demonstrate openness, accountability and a commitment to learning
- provide public assurance to patients, carers, commissioners and the wider community about the quality and safety of our services
- make sure our staff and partners are involved in discussions, in advance of publication, about how we will use the review to help us continue improve quality.

We have agreed a publication date of 18 October 2016 with NHS England. As well as publishing the report on our website, we are proactively contacting the media to offer interviews with our CEO to explain our response to it.

Statement from Colm Donaghy, Chief Executive (to be published on 18 October 2016)

I want to start by saying sorry.

The independent review we are publishing today relates to incidents which had devastating consequences for those affected. I realise this may bring back painful memories for them. I also understand that some, if not all, will feel angry about our services. On behalf of the Trust, I want to offer my sincere apology and condolences.

We commissioned this review with NHS England because we want to make sure we have done everything possible in response to these tragic incidents. We have a responsibility to the patients, families and local communities we serve to ensure this. We have investigated each of the incidents individually. We also wanted independent, expert advice about any common themes which may link them.

Sometimes, as is the case across the NHS, we need to improve processes, policies and training in response to incidents involving our services. But that isn't enough on its own. This review sends us a strong message about the need to identify and embed learning when things go wrong in a way that changes clinical practice and behaviour. This goes beyond action plans; it's about organisational culture, values and leadership.

Another key focus of the report is how we work with patients and families. This is something we don't always get right. We're doing a lot to improve this. But we need to keep at it and keep talking to patients and carers about what we can do better. That includes being prepared to listen to, reflect upon and respond to critical feedback in a positive way. We have appointed people with lived experience of using mental health services to our new, senior Patient and Carer leader roles to help us do this.

We are also introducing Family Liaison Officer roles to provide a single point of contact and support for families affected by a homicide involving someone known to our services. This is something which was recommended to us by families who have been through this tragic experience themselves.

It's important to say that our staff work really hard to provide the best possible care to patients. They make difficult and complex clinical decisions every day and often get things right. I want us to be an organisation which learns when things go wrong and which does something about it, rather than one where people get blamed when they make a mistake. This approach is in the best interests of patients because it will help us continue to improve. It is also why we commissioned this review with NHS England.

Above all, we have a duty to patients, their families and the public to provide the best possible care in the safest way for the people who need our services. I give you my commitment as Chief Executive that we will continue to do everything possible to achieve this.