Bedfordshire & Luton mental health and wellbeing services provided by ELFT

NHS

Thematic Review of Unexpected Deaths across the Luton Mental Health Services from April 2018 - March 2019.

Introduction

The ELFT Senior Leadership Team for secondary mental health services in Bedfordshire and Luton implemented a Quality and Learning from Incidents meeting in 2018 to strengthen local arrangements for learning from incidents. This supplements the Trust's central processes around incident reporting, investigation and learning.

Our approach to investigating incidents resulting in patient harm are in keeping with national guidance. We endeavour to identify root causes and care and service delivery problems, to reduce the risk of similar incidents recurring in the future. We are committed to transparent multiagency arrangements for the investigation of concerns relating to the Safeguarding of Vulnerable adults in order that our services are consistently safe and high quality.

Where a Serious Incident Investigation identifies care and service delivery problems, these are carefully explored and appropriate actions designed to improve care and service delivery across the wider organisation. This is standard practice even where the identified problems have not been identified as contributory to the tragic outcome.

The Trust is committed to a zero tolerance strategy for suicide and is working with BLMK ICS and Public Health England on multiagency initiatives to prevent deaths by suicide. We have populated an action plan around the NCISH '10 ways to improve patient safety' recommendations (appended).

The Trust hosted a suicide prevention symposium in July 2019 which was well-attended by Trust staff and system partners. Trust-wide risk assessment and safety planning training is being updated. Across Bedfordshire and Luton, *Connecting with People* training has been delivered to around 1/3 of our clinical staff.

Additionally, a Trust-wide independent review of our arrangements for patient safety and our safety culture has been undertaken by Professor Carl Macrae, Centre of Health Innovation, Nottingham University. Professor Macrae's findings are currently being reviewed by the Trust Board.

This report addresses unexpected deaths of individuals currently or recently (within the past 12 months) in contact with secondary mental health services in Luton and reported on STEIS from April 2018 to March 2019.

Data

In 2018-19 there were fifteen unexpected deaths warranting further investigation that we reported to the (CCG) as serious incidents. Two of these incidents were de-escalated with the agreement of the CCG. It should also be noted that one death was deemed unascertained by the coroner. In two further cases, death is believed to have occurred due to a physical health condition. This leaves 10 deaths where an individual is believed to have taken their life. This report primarily focuses on these deaths but will also cover learning from the other deaths.

STEIS Deaths 2018-2019:

Method of death	Female	Male
Physical illness - not expected	0	2
Unknown	1	0
Suspected Suicide	3	7

For comparison, we have included data from previous years:

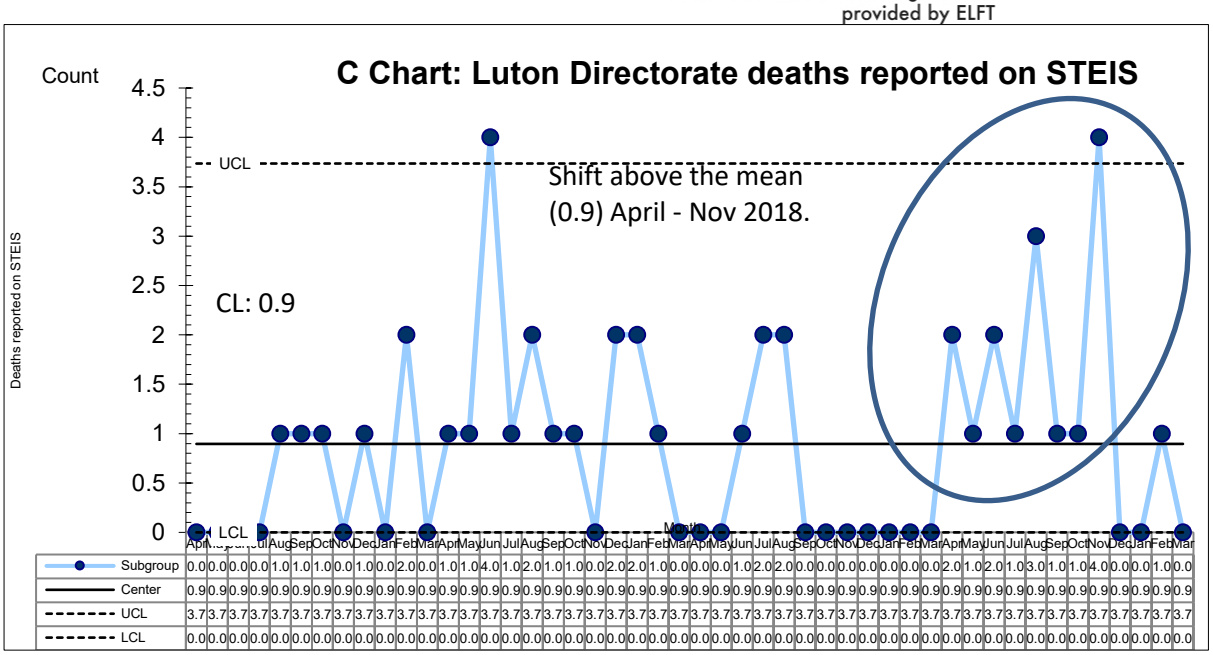
Period	Number of SIR completed	Number of apparent deaths by suicide
April 2015-March 2016		6
April 2016-March 2017	18	16
April 2017-March 2018		7
April 2018-March 2019	15	10

In reviewing serious incidents reported to the CCG following a death we can see that relatively few were reported in the 2015-16 year. The reasons for this are not clear but of note, the provider Trust changed in this year and it is possible that there was a time lag in the collection of some data meaning that cases may have been carried through to the following year's data set in error.

The *annual* numbers in the table above must be interpreted with caution since different sampling windows have been applied in previous years. For this report, deaths *occurring* from 1.4.18 to 31.3.19 have been included. Rather than deaths *recorded* within this timeframe.

From April 2018 – November 2018 there were four *monthly* data points where monthly reported deaths were above the mean, with one data point outside of the upper control limit. There was at that time a significant concern about an emergent trend with increasing unexpected deaths.

Fortunately, the number of unexpected deaths reported each month would appear to have reduced to/below the mean in recent months.



It is important to consider the national context here.

The most recent Office for National Statistics biannual report highlights an increase nationally in deaths by suicide with particularly concerning increases in males in the East of England.

Although not directly relevant to this report, since our investigations are generally concluded in advance of Coroner's Inquests, is the change from a criminal standard of proof to a civil standard, in relation to suicide verdicts. Since 2018, Coroners have been applying the 'balance of probabilities' test which is likely to result in an increase in the number of suicide verdicts reached.

This Report

The incidents covered in this report have all been reported on STEIS and either had a 48 hour report before de-escalation or have had a full Serious Incident report submitted. This data is derived from Datix and shows the directorate that was assigned to the incident.

In two included cases, it is now apparent that the incident had been reported to Bedfordshire CCG. However to avoid any risk of data being missed between the two directorates we have included any incidents that were attributed to Luton Directorate on Datix on the basis of services accessed at the time of death, for example where a Bedfordshire resident has accessed the Luton and South Beds CRHT.

This report is structured to cover:

- Demographic data with associated themes
- Predictability and preventability
- Overarching themes
- Strategic action plan

Demographic Data and Associated Themes

These data have been cross referenced with the ONS report on deaths by suicide registered in 2018.

1. Gender

Male deaths by suicide predominate in our sample, which is in keeping with the national picture. Male deaths nationally account for around ¾ of suicides.

Luton sample:

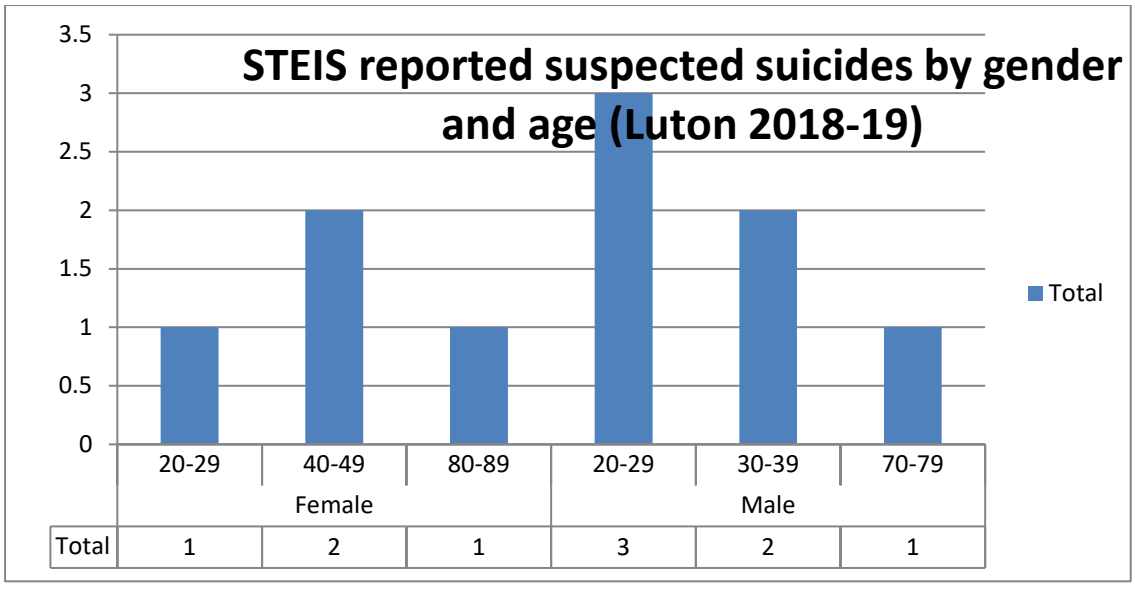
70% male

30% female

2. Age and Gender

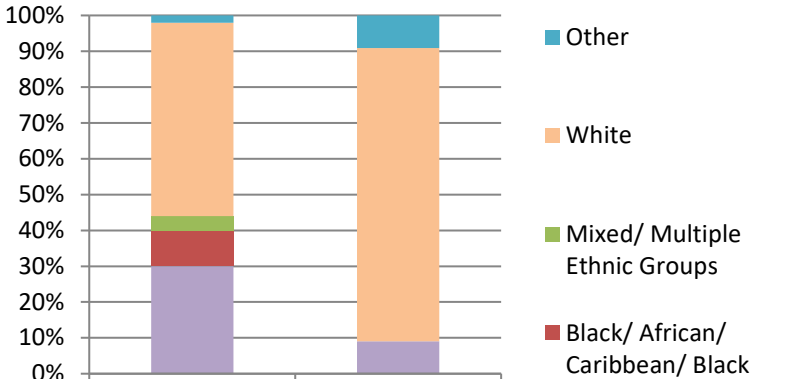
For suicides in the UK: 2018 registrations report demonstrated that men aged 45-49 had the highest age specific suicide rate nationally, for females the age group with the highest suicide rate was also the 45-49 group.

Looking at the age and gender of each case in Luton in 2018-19 we can see that the female age group with the highest STEIS reported death rate is the 40-49 group and that the male age group with the highest STEIS reported death rate is the 20-29 group. If the unknown and physical causes of death are removed, leaving just suspected suicides there is still a concentration of male deaths in the 20-40 age range with the number of deaths reported as suspected suicides in Luton decreasing as age increases. Luton's relatively young population and the small numbers in our sample here must be considered here.



3. Ethnicity

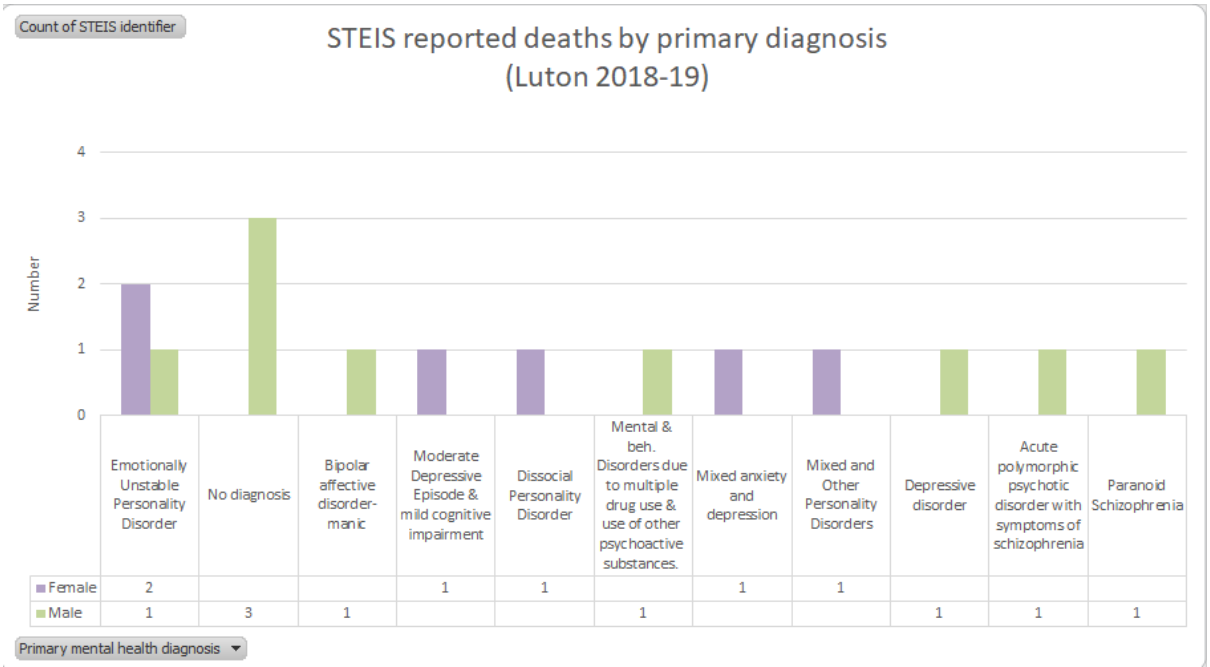
As reported in the mid-year review the majority of deaths were from people of a White-British ethnic group. The chart below shows that deaths have most commonly been reported in relation to a White British service user. The 2011 census data for Luton is compared to the reported deaths below.



	2011 census %	Susp. suicide on STEIS%
Other	2	9
White	54	82
Mixed/ Multiple Ethnic Groups	4	0
Black/ African/ Caribbean/ Black British	10	0
Asian / Asian British	30	9

Compared to the 2011 census data there is a disproportionately high number of suspected suicides reported in the White ethnic group (82% of suspected suicides reported on STEIS were attributed to people in the white ethnic group compared to 54% of the population being reported as white in the census).

4. Recorded primary presenting problem/diagnosis

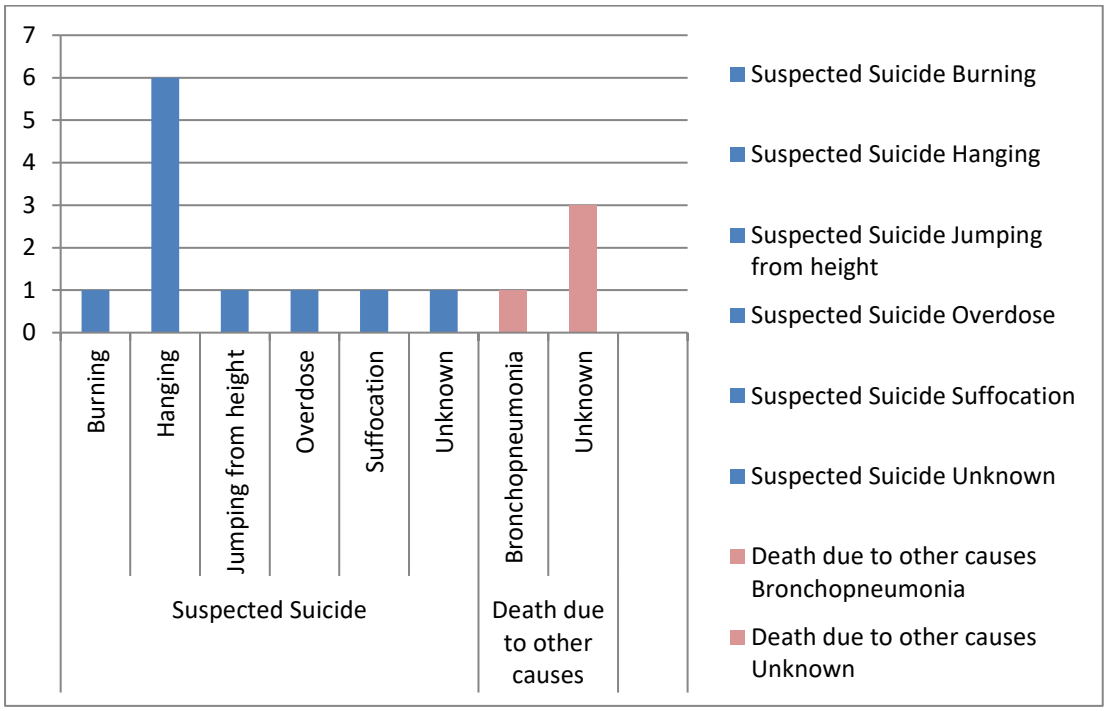


Recorded diagnoses at the time of death are recorded in this table.

Personality disorder was diagnosed in 4/10 of those in this sample. Affective disorder, psychotic illness and disorders associated with substance misuse also feature here.

5. Causes of Death

In keeping with the national data, hanging was the most common causes of death in this sample.



6. Service Contact at Time of Death

The Luton and South Bedfordshire Crisis Team featured in four of the deaths by suicide here. When the crisis care pathway is considered in its widest definition, more than half of the deaths here had been in contact with these services. This is very likely to reflect the acuity of presentations within this part of our services but has nonetheless been an area of focus for our work on improving safety and quality of care.

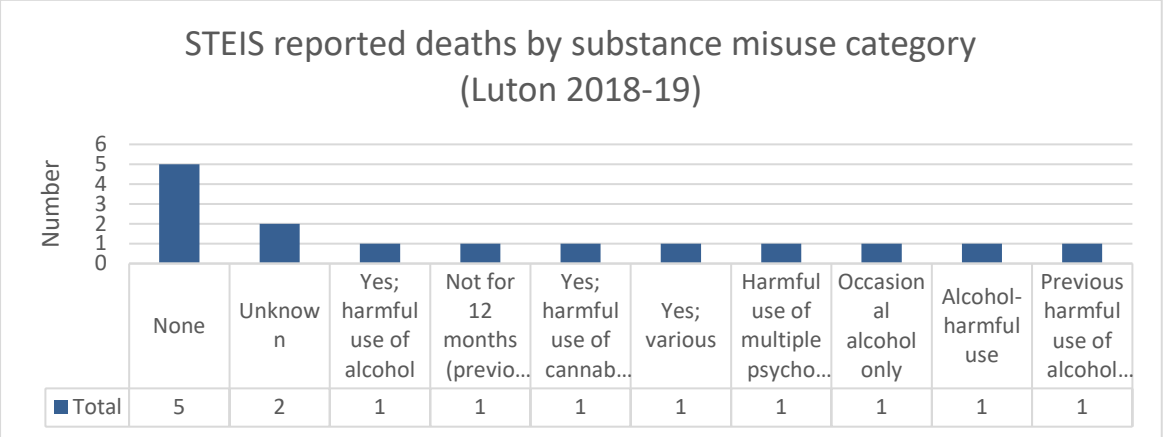
Team	All deaths reported on STEIS	Suspected suicides
Luton and S Beds CRHT	4	4
Stockwood CMHT	3	2
Section 136 suite	2	1
Brantwood CMHT	2	1
PICU (Jade)	1	1
Poplars Ward	1	1
Memory Assessment Service	1	0
Court Liaison and Diversion	1	1

7. Unexpected death and relationship status

Relatively few (two) of the service users were noted as being in a relationship at the time of death.

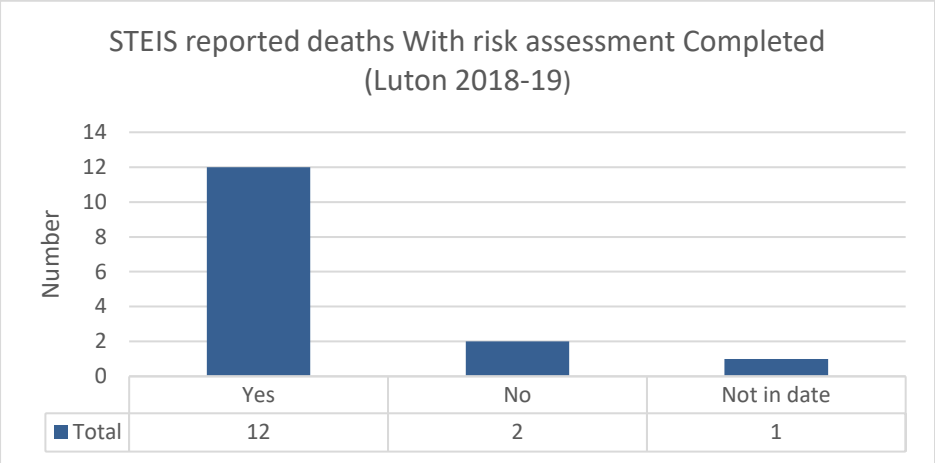
	All deaths on STEIS	Suspected Suicide
In a relationship	2	1
Not in a relationship	11	9
Unknown	2	1

8. Substance misuse



The use of alcohol or cannabis or other psychoactive substances feature more often than not in this sample. However this must be interpreted with caution. In the majority, incidental use of substances was recorded. It is striking that the vast majority were not accessing support from substance misuse services and this was mostly due to not consenting or identifying this as a priority.

9. Was risk assessment completed?



The Trust's clinical risk assessment policy is under revision currently. There will be an enhanced focus on collaborative safety planning within this document, in addition to clearer guidance on when to use the full in-line risk assessment schedule and when a progress note entry is sufficient.

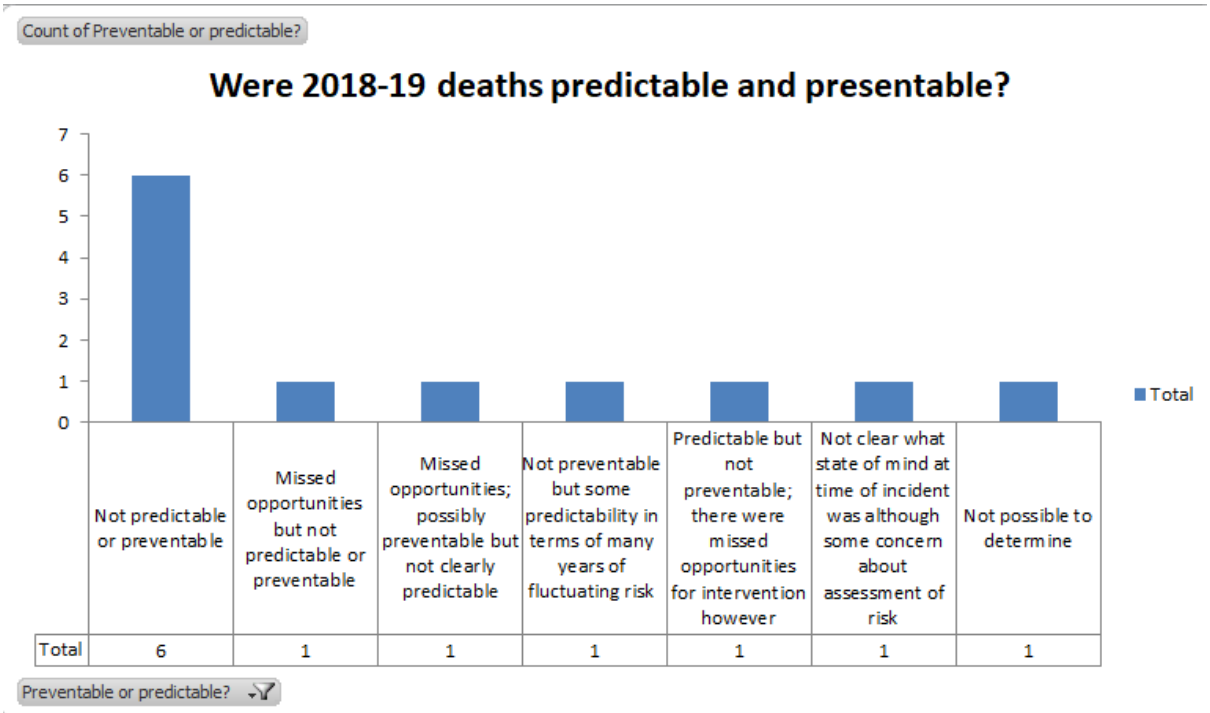
There were examples here of risk assessments not being updated in the context of CPA and inpatient discharge. The circumstances in which this arose have been addressed individually.

10. Predictability and Preventability

The investigating team strive to reach a conclusion about root causes of a given incident, in addition to indications as to predictability and preventability.

As the following table outlines, missed opportunities for contact were identified in four cases here. It is difficult to know what the outcome of such contact might have been for the individual.

Applying our DNA policy; tightening up 72 hour follow-up; improving crisis care pathway communication and responsiveness; improving the delivery of compassionate care have been amongst the actions taken to address circumstances identified in individual reports.



Thematic Review:

The following overarching themes have been identified through this review:

1. Personality disorder; high prevalence of personality disorder in this sample (4/10 apparent deaths by suicide)
2. 72 hour follow-up
3. Prevalence of substance misuse and lack of engagement with Resolution or equivalent services
4. Support to families, carers, recording of next of kin and *thinking family* in caring for patients
5. Standards of documentation, communication of information
6. Crisis care pathway communication

Strategic Action Plan

The following action plan is not an exhaustive capture of every action generated by our investigation of these incidents; rather it is a synthesis of the higher level actions and strategies which we are deploying to address recurrent concerns and problems.

This action plan builds upon and complements initiatives already in place.

Theme	Action taken	Plans
Personality disorder	EUPD working group Business case for expansion of service Reimagining Luton crisis pathway for individuals with personality disorder-in development	Alternatives to admission for individuals in crisis Revised risk assessment and safety planning training roll-out
72 hour follow-up	Protocol for 72 hour follow-up (latest stats appended) Co-produced script for 72 hour contacts to maximise benefit	PDSA and refining the process of 72 hour follow-up
Prevalence of substance misuse and lack of community take-up	Improved liaison and dual diagnosis interface with Resolution	Reimaging Luton shared points of access with mental health and Resolutions
Support to families, carers	Qi project on family and carer involvement on Coral Ward Compassionate care project across services RIO guidance around recording next of kin	Training for pragmatic application of confidentiality Think family training
Crisis Care Pathway	Single directorate New CD Qi project addressing trusted assessments across PLS and CRHT Review of operational policy in relation to disengagement	Revision of medical establishment 24 hour crisis care Alternatives to inpatient care

Dr Dudley Manns **Ms Claire McKenna**

Medical Director **Director of Nursing**

December 2019

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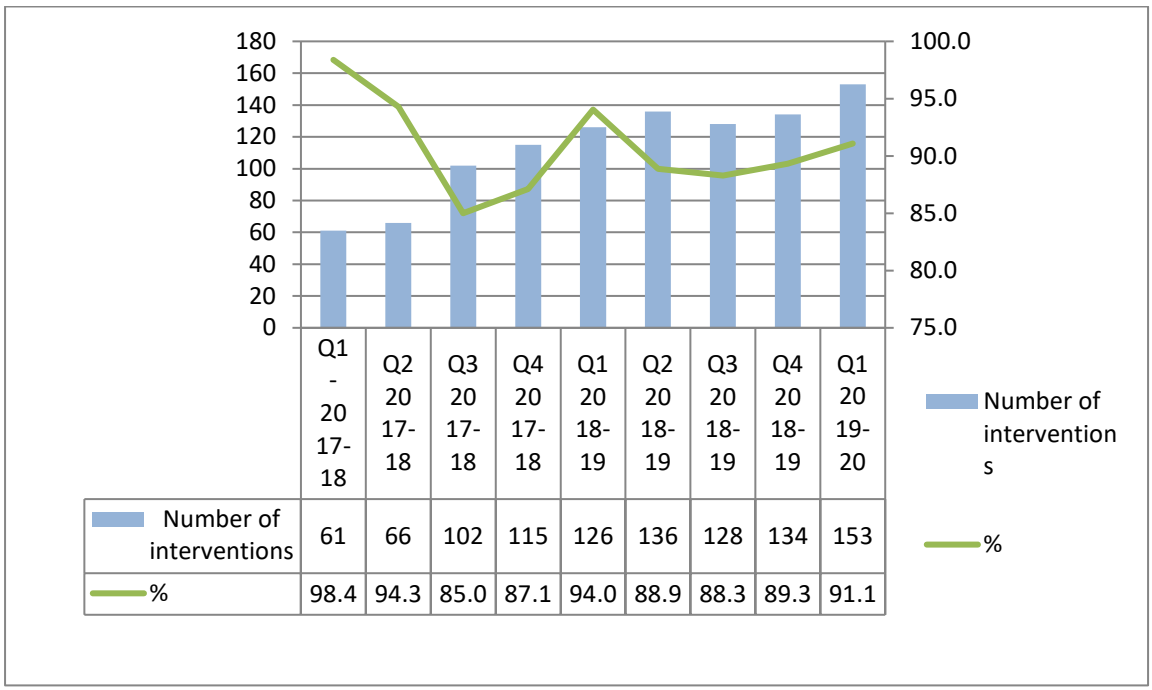
Appendix 1: Follow-up following inpatient discharge:

Seven-day follow-up of all individuals who have accessed inpatient care is a high priority patient safety indicator for the Trust, since the days following discharge are associated with an elevated level of suicide risk. Accessibility of local admission beds, strong links between community and inpatient teams together with administrative and IT processes to support this are all areas of ongoing work in Luton.

All service users discharged from the ward regardless of their CPA status. Additionally since April 2019 we have focussed on ensuring that the interventions are offered earlier in the week.

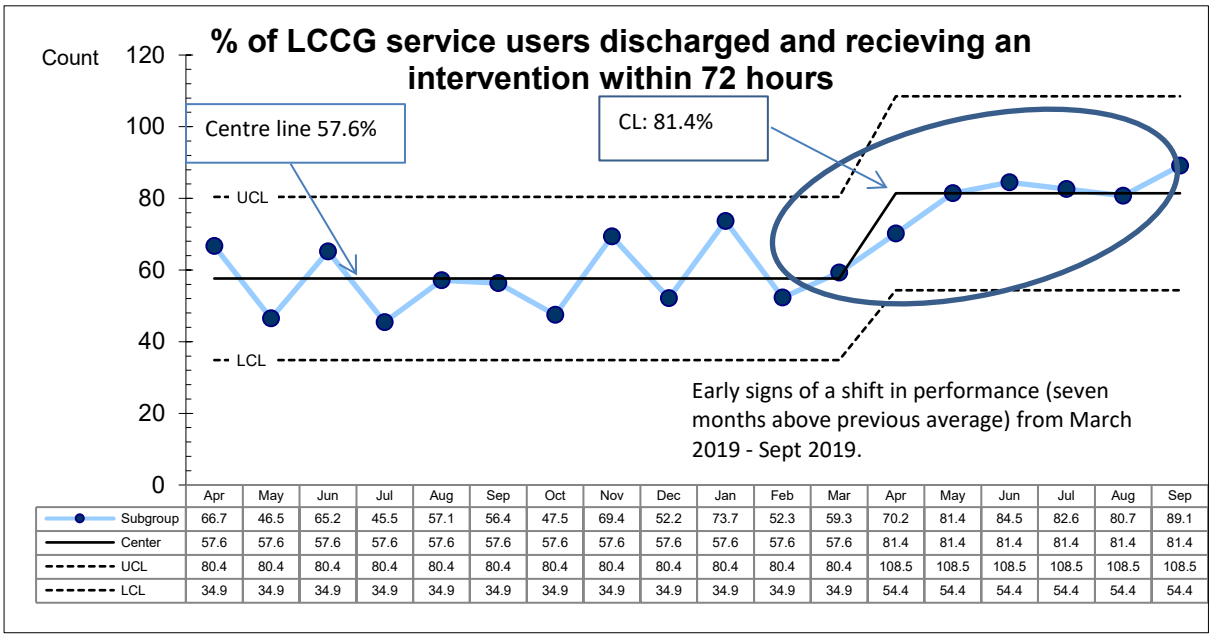
While our performance as a percent of discharges receiving an intervention within seven days has shown a deterioration the actual number of LCCG service users who have received an intervention within seven days of their discharge has significantly increased meaning that more people receive support and a risk assessment during the high risk period following discharge. The chart below shows the nationally reported performance against the seven day intervention target (data only available to Q1).



	Q1 - 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19	Q1 2019-20
Number of interventions	61	66	102	115	126	136	128	134	153
%	98.4	94.3	85.0	87.1	94.0	88.9	88.3	89.3	91.1

This means that we are reaching more service users at a point when we know they are most vulnerable.

It is well known that the risk of committing suicide is highest in the first three days following discharge. In March and April 2019 we reminded staff of the importance of carrying out this intervention within the first three days and are pleased to confirm that since then there has been a sustained shift in performance with more service users (CPA and non CPA) receiving their suicide prevention intervention within the first three days after their discharge.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Subgroup	66.7	46.5	65.2	45.5	57.1	56.4	47.5	69.4	52.2	73.7	52.3	59.3	70.2	81.4	84.5	82.6	80.7	89.1
Center	57.6	57.6	57.6	57.6	57.6	57.6	57.6	57.6	57.6	57.6	57.6	57.6	81.4	81.4	81.4	81.4	81.4	81.4
UCL	80.4	80.4	80.4	80.4	80.4	80.4	80.4	80.4	80.4	80.4	80.4	80.4	108.5	108.5	108.5	108.5	108.5	108.5
LCL	34.9	34.9	34.9	34.9	34.9	34.9	34.9	34.9	34.9	34.9	34.9	34.9	54.4	54.4	54.4	54.4	54.4	54.4

Appendix 2: NCISH-Safer Services Plan

Suicide Prevention Plans Bedfordshire and Luton 2019/2020

Safer wards	Working with police to reduce AWOLS Yearly ligature audits & daily environmental checks Inpatient staff have received suicide prevention training Daily huddles (violence reduction collaborative and also general safety and observations) Nursing band 3-8 development programmes including risk assessment, care-planning and safety-planning alongside collaborative working with patients Co-produced risk assessment, 'my safety plan' and care-planning for inpatients Quality improvement work addressing meaningful family and carer involvement during inpatient admission and for discharge planning P2R and CGL in-reach to inpatient units Staff training on dual diagnosis and intoxication effects Bimonthly away-days with learning lessons events, reflective practice and patient stories (in development) Clinical improvement group meetings to disseminate best practice and learning

	Quality improvement training, projects, forum with patient involvement Trust-wide review of observations and Qi project to improve quality and impact of observation practice Prompt discharge notification and TTA provision through service-led redesign of pathways
Early follow-up post discharge	72 hour follow-up process for all discharges; coproduction of script (what patients value) and refining process through PDSA cycles Monitoring system in place with real-time feedback and chasing up breaches from assurance team; longer term improvements overseen through healthcare governance and DMT CRHT visit ward and input to early discharge decisions/planning Joint inpatient and crisis pathways forum to discuss interface and performance issues Twice weekly bed meetings to improve transition from inpatient to community Webex facility between CMHTs and inpatient units to facilitate liaison between services around transitions Enhanced duty systems, consistent practice across teams with RAG rating Values-based training with staff around 'no wrong door' and no such thing as an 'inappropriate referral' Trusted assessments across crisis pathway
No out of area admissions	Bed management Qi project Improved local bed resource management; dramatically reduced need for admission to London Trust beds and where needed, arrangements made for repatriation through strengthened points of liaison and escalation pathways aiming for local discharge from Luton and Beds inpatient care Current review of series of admissions to explore alternatives to admission where appropriate and to refine community pathways/response Housing and local authority work to improve transition to housing support on discharge; to refine pathways and reduce delayed transfers of care
24 hour crisis teams	Funding agreed to extend Luton and Bedfordshire CRHT to 24 hour functioning and plans underway to implement this Crisis café, community-led crisis resources are in development MHST and CLDT SIM project NHS 111 pathway
Family involvement in learning lessons	Involved in SI process in setting questions Active process of involvement/contact with relevant service after an incident involving a family member

	Examples of using service user/family narrative in staff training and learning lessons events where appropriate Development of a patient/carer interview library for access by services (with reduced likelihood of re-traumatising affected individuals)
Guidance on depression	Accessible NICE guidelines and multidisciplinary forum to review updates to all NICE guidance Expanding primary care mental health resources to enhance understanding of diagnosis and treatment of depression
Personalised risk assessment	My safety plan developed collaboratively with staff and patients Connecting with people training Personalised approach to risk assessment and management encapsulated in Trust policy Routine audits of risk assessment (completion of assessments and also assessment of quality of assessments)
Outreach teams	RAG rating and targeted assertive approach to hard-to-engage individuals within community mental health teams AMHP service improvements; consideration of S12 app EIS offers ageless assertive care
Low staff turnover	Comprehensive recruitment and retention strategy across all professional groups Reducing staff turnover across all professions Enhanced support to help development within professional roles to improve job satisfaction and retention Team development (compassionate care project) Leadership development initiatives and manager training Enhanced staff support through service transition
Services for dual diagnosis	Revised dual diagnosis policy Revised service model with joint-working, care-planning Inpatient teaching