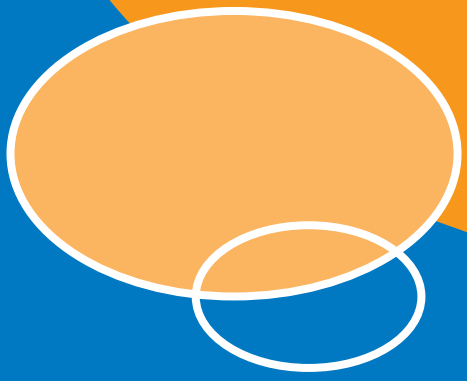
# Report and Learn Bulletin

August 2008



Sussex Partnership NHS
NHS Foundation Trust

# Contents



**Report & Learn Bulletin August 2008**

**Welcome to the August issue of the Report & Learn Bulletin. In this edition you will find:**



## Learning from SUIs Lone Worker Policy and Local Procedures

**Paul White**
**Head of Risk and Safety**

A staff member sustained serious injuries recently during a routine home visit when the service user threw a kettle of boiling water at them.

The staff member in question was experienced and conscientious, and had extensive knowledge of the service user in question. There were no particular predicted concerns and the incident was considered to be an 'out of the blue' and unexpected event. Lone staff members regularly visited the service user as the risk of harming staff was considered to be low.

The final report into this SUI established that the Trust's Lone Worker policy had been adhered to and practical measures considered in relation to lone working. However, it identified that there were areas for review and development in relation to the local lone working protocols for this team, to build on existing good practice.

The Health & Safety Executive (HSE) also reviewed this incident, as the Trust was required to report it to them under RIDDOR arrangements. They have concluded they will not be taking action against the Trust, but have advised that the Trust should ensure that local Lone Working Procedures are in place for all teams.

Please consider this incident and ensure that your team has local procedures in place to minimise the risk of assaults on your staff. For further guidance on producing a Lone Worker Procedure please see the Trust's Lone Worker Policy on the intranet, and the HSE's

case studies on nurses/carers work related violence at Hse.gov.uk/violence/hslcasestudies/Birmingham.htm.

## Transition between services

**Dr Tim Ojo**
**Chair, Brighton & Hove Locality Clinical Risk Group**

At their meeting in June, the Brighton & Hove Locality Clinical Risk Group reviewed the case of a nineteen year old man who had been found dead in the supported accommodation where he had been living. The cause of death was due to poisoning from medication which was not prescribed for him.

The young man had received ongoing support from CAMHS on an intermittent basis for several years and support from voluntary agencies. He had been discharged from CAMHS on reaching his 18th birthday, but it was decided not to refer him to adult mental health services. Within a month of discharge the service user was having difficulties with his alcohol / substance misuse problems and struggling with accessing mental health care, failing to attend for appointments. However he continued seeing voluntary sector community youth services.

The SUI final report established that whilst a number of different agencies were involved in supporting the service user, there was limited joint discussion between voluntary and statutory agencies on how best to support him.

The report also found that the service user was very vulnerable and had been the victim of previous assaults in the year prior to his death. He had declined offers of intervention from his housing provider, including moving him to other accommodation away from the alleged perpetrators, his actions may have been related to fear of intimidation and repercussions.
The report identified some confusion about information sharing and team responsibility for Safeguarding Vulnerable Adults (SVA) alerts and which may have impacted on the speed of response to the alert and the level of support offered to the service user.

Key issues highlighted for improvement as a result of this SUI were:

- Transition between CAMHS and WAMHS - where a young client who continues to suffer mental health or substance misuse difficulties but who may not wish to see adult services is reviewed by CAMHS / WAMHS / SMS prior to discharge to provide a clearer support pathway for all agencies and family involved. This should include an agreed process to collate reports from GP, A&E and Out of Hours services.
- How are voluntary agencies supporting complex and high risk service users linked and supported by statutory mental health and substance misuse services?
- Safeguarding Vulnerable Adults procedures - as in this case, at a time of structural change to teams and staff groups SVA alerts can be slowed and receive a less than full response
- To consider involvement of carers, this case identified a family member who was able to link with voluntary services but had little access to mental health services.

The Brighton & Hove Clinical Risk Group considered how these issues might be addressed more widely:

- Work is being undertaken between the Trust and PCT to develop more integrated statutory / voluntary service for adolescents and young people in mental health and substance misuse.
- The SVA pathway must be reviewed to ensure that the necessary skills and experience still exist in newly created teams. In this case a new SVA pathway for alerts was agreed between community Access and Recovery working age services.
- The new Carers' charter identifies the need for staff to be trained in working in partnership with carers, including positive and appropriate information sharing and listening to carers.

## Review of key messages from Suicide and Homicide group - West Sussex Locality

**Seamus Watson, Associate Director**
**Chair of West Sussex Locality Suicide and Homicide Group**

Following case reviews of SUIs in West Sussex locality from January to July 2008 there have been a number of consistent themes emerging regarding how we identify and reduce the risk of suicide and serious untoward incidents in our practice. Many of these are recognised both locally and nationally, but there have also been additional key messages for practitioners, professional leads and service managers.

This 7 month review has confirmed the key interventions which underpin best practice. These are by no means new messages for us, but they do reinforce our continued need to concentrate on:

- Ensuring risk assessments are undertaken at an early point of contact with service users
- Ensuring these assessments are documented and reviewed at times when service users are experiencing a change in their circumstances or mental health
- Including carers and family members in risk assessment and risk management planning
- Having risk assessment and management plans available 24 hours daily / 7 days weekly
- Having crisis and contingency plans in place
- Communicating effectively with all practitioners involved in support

This review has also identified a number of additional key messages which have been identified by teams undertaking SUI investigations and from discussions within the Suicide and Homicide group:

- There have been a number of cases presented where long standing physical health problems, often with associated pain have increased the vulnerability to risk of self harm
- When reviewing a serious untoward incident involving a younger person, there was an acknowledgement that the Serious Case Review process was required to ensure the broader involvement of colleagues from education and younger persons services the review process
- Local media reporting of suicides was identified by a community team as an influencing factor when understanding the risk assessment of a particular service user

It is clear from the reviews that there are many examples of good practice already in place within the Trust, and equally that there is an ongoing need to ensure that we concentrate on ensuring that risk assessment and management is a priority area for our training and development plans and that this important practice issue is routinely addressed within the supervision process.

There are also a number of additional interventions in place to support best practice in West Sussex locality:

- The locality Risk Management and Review Panel has been reviewed and changed to have an increased focus on a root cause analysis approach to understanding risk and risk management
- The locality is developing a multi agency Suicide Prevention Strategy, with a consultation event planned for September 10th - National Suicide Prevention Day

## Trends & Lessons Group

**Denise Caro**
**Report & Learn Facilitator**

The Trends and Lessons Group met in July and received reports from Mental Health Act Services Manager, Customer Relations, PALS, Health and Safety, SUIs and Medicines Management. Key

issues for Trust wide learning were highlighted:

**Mental Health Act Administration**
Feedback from the Mental Health Act Commissioner following visits during the first quarter to eleven inpatient units across the Trust identified areas for improvement relating to the following:

- S17 leave documentation
- Poor compliance with the recording of assessment of patients' capacity to consent to hospital admission and medical treatment as well as issues relating S58
- Explanation and recording of patients' rights under S132
- Compliance with CPA
- Compliance with Form 38/39

The Commissioner was please to note good practice in individual units and this has been communicated to the units/wards concerned. Feedback noted the dedication of staff in providing a relaxed and therapeutic environment and good interaction with patients, and the range of activities available to patients in some wards.

**SUIs**
Key issues arising from SUI Final Reports approved and received during the period 1 April to 30 June highlighted the need to:

- Improve inter-professional communication systems relating to assessment, handover, referral, discharge and transfer of care.
- Reinforce the need for multi-disciplinary consultation where there is concern about a service user or different perspectives regarding treatment and record the decision making process
- Ensure full compliance with CPA process

## Patient Advice and Liaison Service (PALS)

**Rachel Kenny**
**Patient Advice and Liaison Service Manager**

The Patient Advice and Liaison service resolves problems and concerns on behalf of service users and carers who contact them. This is undertaken on an individual confidential basis. However, over each quarter themes and cases emerge that have a wider significance for the quality of trust services.

During April to May 2008 these were:

- **Lack of mental health advocacy**
  Enquirers continue to identify significant problems with regard to older people's mental health advocacy in East and West Sussex. Whilst there are limited generic advocacy services for older people that will take on less complex mental health issues, there is no specific expert funded service available at present in the counties. An associated concern was raised about the low level of older service users' participation in local service reorganisation in East Sussex.

In Brighton and Hove adult mental health service users continue to describe problems obtaining timely advocacy as local services having closed or long waiting lists.

- **CRHT**
  Service users and carers expressed unhappiness about the provision of CRHT in East Sussex. Issues raised were: difficulties accessing the service, the quality of advice given in a crisis situation and carers' input not being given weight.

- **BSL Interpreting**
  An enquiry highlighted the need for a trust wide policy for engaging a BSL interpreter for a deaf person.

## Lessons Learned from Complaints

**Peter Lee**
**Customer Relations Manager**

77 complaints were received between April and June, 53 were handled formally under the NHS complaints regulations and 76% of these were responded to within the agreed timeframe. Of the 77 complaints received, 52 were made by someone other than the service user; 27 were from a relative and 6 through an independent advocacy service.

The customer relations team ensure that the options for making a complaint are clearly set out, and that people are signposted to appropriate advocacy services. If a person finds it difficult to express their concerns in writing, a meeting is offered and sometimes complaints are received verbally over the telephone. More people are telling us about their concerns by email and this helps to ensure their feedback is received without delay. Whenever the customer relations team receives a complaint, a specific team member is assigned to that complaint until its conclusion, and they will also always try to make contact verbally, when this is appropriate.

The customer relations team encourage staff to consider and resolve concerns locally, and help is always offered to help reach the best possible outcomes. When someone expresses a wish for their concerns to be handled under the NHS complaints regulations a member of the team will establish the nature of their concerns and reassurance will also be given that appropriate action will be taken as a result of any failings they or the Trust identify.

Some of the complaints received during the last quarter identified concerns about older people's mental health services:

- Incomplete personal property documentation during admission to an inpatient ward resulted in the loss of jewellery
- Lack of provision of chiropody services for long stay inpatients
- Injury to a patient whilst they were being restrained highlighted issues around PMVA training for staff.
- Lack of nursing staff and leadership on an inpatient ward
- Lack of support and assessment offered to carers

## Medication Errors

**Jed Hewitt**
**Chief Pharmacist**

An end of year report for 2007/8 was presented to the Trends & Lessons Group in July and was subsequently sent out to Associate Directors for onward distribution to their teams. The year saw a total of 314 medication related incidents reported across the Trust with reporting frequency each quarter being consistently around 80 reported incidents. The majority of reports (57%) came from the West Sussex locality and with regard to care groups most came from working age adult services, (44%).

Just over half of the incidents reported during the year (54%) involved the administration of medicines, rather than their prescribing, supply or recording etc. This figure has again remained fairly consistent each quarter and is also close to the national level that is quoted by the National Patient Safety Agency at 59%. The rest of the errors involved self-administration, prescribing, recording, supply, stock control and other miscellaneous incidents in fairly equal numbers. That administration errors account for the largest number of reports is not surprising as administration is by far the most common procedure associated with medication. However, it is also the part of the process that can result in the patient receiving medication (incorrectly) often without the chance for any remedial intervention and is therefore the part of the process that might reasonably be considered to carry the most risk. It is therefore extremely

important that Medicines Management remains a key component of the 'essential training' provision for nursing staff and that managers are fully supportive of releasing their staff to attend the Trust in-house training events provided by the pharmacy team.

The commonest administration errors are recorded as those involving doses of medication being missed, being administered at the wrong time, being administered in the wrong dose, or being administered twice, (i.e. the dose is duplicated), and combined these account for over 60% of the administration errors reported. In addition there were 17 reported incidences during the year of medication being administered to the wrong patient. All these types of events have been highlighted in the Report and Learn Bulletin and in the Drugs & Therapeutics Newsletter during the course of the year, and are also specifically targeted for discussion during the Medicines Management training days.

The assessed level of risk to the patient has remained largely consistent in each quarterly report, with an over all figure of 83% of incidents during the year presenting only low risk to the patient. If combined with those incidents rated as presenting moderate risk or no risk at all, the proportion is over 98%. Over the course of the year only 6 medication incidents were assessed as putting the patient at high risk, and these all occurred in the final quarter. These incidents involved three occasions when errors occurred in the issue of methadone prescriptions for Substance Misuse Service clients, an inpatient incident involving a significant insulin dosing error, an incident of incorrect issue of medication at discharge, and an incident where poor stock control had resulted in several medicines being returned to the wrong stock boxes after the administration round. Team managers appropriately followed up all these matters and important learning points were cascaded to staff.

During the course of the year, our over all level of medication incident reporting was simply benchmarked against that of neighbouring partnership trusts. It was encouraging to find that our level of reporting is currently significantly higher than that of our neighbours in Kent and Surrey.

In an attempt to stimulate a still higher rate of error reporting across the Trust, the pharmacy team ran a one-month intensive reporting campaign in June. This was targeted at all clinicians in both inpatient and community teams and employed a very much simplified medication error reporting form. A full report of this campaign will be available in a few weeks time once all the data have been analysed, although some preliminary figures have been gathered. For example, over the course of the month close to 1000 medication incidents were reported, although members of the pharmacy team reported almost 95% of these. Half of the reports related to working age adult units, 38% to older peoples services and 12% to the secure and forensic service. This last figure is the most interesting as the annual figures recorded less than 2% of the total medication incidents coming from this service. This would suggest a significant under-reporting by the secure and forensic service during the course of the year and a need for much greater levels to be achieved in the future. When looking at reporting by type, 55% of errors reported during the month were considered to be administration errors and this figure is remarkably consistent with the annual percentage of 54%. In analysis of these incidents, over 80% involved the non-completion of the medication administration record. This is obviously a very high proportion and this is an area that will need to be particularly focussed on by nurse managers and their teams, especially as recording the administration (or omission) of medication doses is such a basic requirement of nursing practice and Medicines Management. Another area that will need renewed focus is the completion of allergy status boxes on the prescription chart. 42% of the month errors related to prescribing and almost 40% of these to blank allergy boxes. Clearly, a lack of consideration of allergy status prior to prescribing or administering medication presents

a high risk to the patient and this is something that will be further stressed to medical and nursing staff during training and induction events. On-going reminders will also be issued via pharmacy bulletins.

A full-copy of the end of year medication incident report is available on the Trust website and a full report of the intensive reporting month will be available in the near future.

## Updates
## Local Security Management Specialist

**Andy Norman**

**Reporting violence against staff**
There is some confusion amongst managers as to whether the Trust adopts the policy of reporting incidents of violence against staff to the Police. Legislation laid out by the Secretary of State (Direction November 2003), and the Security Management Service report 'Tackling Violence Against NHS Staff' November 2003, states that 'the police must be contacted in all cases of physical assault'. For further clarification please contact: 01323 444154 or email: andy.norman@sussexpartnership.nhs.uk

**PMVA**
Tutors are now providing PMVA training for staff working in older people's mental health services. The first 5 day course taking place at Millview Hospital in the week beginning 1 September is fully subscribed, and it is anticipated that some Breakaway training will be provided in October 2008. The 5 day course in September will provide a benchmark to establish if the course content meets requirements or needs modification.

The new intake of 40 junior doctors in August will be attending a PMVA Breakaway course in September across four Trust sites:

| | |
|---|---|
| Week 1 | Haywards Heath, West Sussex |
| Week 2 | Ashen Hill, East Sussex |
| Week 3 | Swandean, West Sussex |
| Week 4 | Millview Hospital, Hove |

Each course will have 2 tutors and 12 students and the session in Week 4 at Millview Hospital will provide an opportunity for any doctors who missed their allocated slot to attend. It is intended that this training will be an annual project.

For further information about PMVA training please contact: 01323 444154 or email: andy.norman@sussexpartnership.nhs.uk

## Star Wards

**Bob Titherington**
**Practice & Development Facilitator, OPMHS, East Sussex Locality**

Star Wards is a national initiative, supported by DoH and NIMHE, which was instigated in 2006 by a user of adult mental health services. The project aims to focus on the inpatient environment and therapeutic activity available to patients, with the intention of demonstrating links between this, and improvement in satisfaction and recovery rates of patients and a corresponding reduction in the incidents of violence and disruptive behaviour.

This project was initially aimed at adult inpatient units and there are now over 250 units around the country participating in this scheme with considerable enthusiasm, and reporting the benefits of implementing this project to both staff and patients.

When I took up a secondment to Practice Development in February 2007 I saw the Star Wards project as a way of addressing a number issues that had been identified on the inpatient units through a number of sources. These included: The OPMH Service Review; feedback from complaints; and areas for improvement identified by staff on the units.

A Steering Group was set up and the Star Wards project adopted within OPMH Services (I believe the first OPMH service in the country to take up this project).

The project began by listing the 75 good practice ideas and posting these on the wards over a 5 week period. We asked staff, patients and carers to comment on which ideas they felt would be beneficial in enhancing the inpatient stay in hospital and improving recovery.

As part of this initial consultation a benchmarking exercise was undertaken on each ward against the Star Wards 75 ideas to identify the status of each ward in terms of developing a therapeutic environment, as we were aware of existing pockets of good practice.

A link person(s) was identified from each unit to join the Steering Group and disseminate ideas and feedback. It was felt that this should be a multi-professional group so that there was a pool of expertise available to progress ideas and overcome any problems encountered. Therefore the following persons were recruited: a Senior Manager; PALS representative; Voluntary Services Co-ordinator; Senior OT; Senior Clinical Psychologist; Nursing reps. from each Unit and Day Hospital; and a Service User.

OPMH services registered with the Star Wards national database and receive monthly newsletters. Together with representatives from each unit, I attended the first national Momentum Conference in Stafford in July, chaired by Malcolm Rae from the DoH and addressed by Professor Louis Appleby, which provided an opportunity to network with other Trusts from around the country and share good practice.

Each OPMHS ward has continued to develop a number of the 75 good practice ideas which include: Protected Therapeutic Time, a programme of Therapeutic Activities both OT and Nurse led, Protected Mealtimes, Sacred Spaces, and entertainment and leisure activities such as regular comedy evenings, outdoor activities, bingo, musical sessions etc.
The Steering Group continue to meet monthly to feed back and share good practice. We also try to involve as many people as possible in the project by spreading the philosophy of therapeutic working throughout teams and departments. To this end I am planning a series of lunchtime 'road shows' to promote the concept of Star Wards and get as many people involved as possible.

A number of audit measures are being planned to evaluate the benefits of Star Wards:

- I am currently repeating the initial benchmarking exercise to measure how far we have progressed with implementation.
- An audit of nurse led activity has been collected and it is envisaged that this can be measured against, and demonstrate, a reduction in the number of aggressive and untoward incidents; an increase in patient and carer satisfaction; and a reduction in the reliance on medication to manage behaviour.

If you would like more information on the Star Wards project and the progress we are making please contact Bob Titherington 01323 648475.

## Risk Indicator Pro-forma

**Tony Flynn**
**Acting Health & Safety Manager**

The annual completion and return of the Risk Indicator Pro-forma, or RIP as it is better known, is a Trust mandatory requirement for all home, ward and department managers. Many managers who have been through this process before have completed, or will be in the process of completing, their 2008 return. The pro-forma is designed to assist in identifying areas of significant risk. Managers new to this process may wonder where to start and what to do with the pro-forma once they have completed it. Hopefully, this guide will help you on your way and answer some of those questions as you proceed.

There are three stages to this process; namely the audit, action plan and risk assessment.

**1. RIP Audit**
The document contains a number of criteria ranging from physical environmental to medications management and security. It is important to mention at this stage that the majority of questions will require confirmation by the manager that what you are stating as being in place can be evidenced at a later date. Each question will require either a 'tick' indicating yes, or 'H' indicating that this particular issue cannot be evidenced.

Not all criteria will be relevant to your department, so inserting N/A (not applicable) should be applied. At the end of each criterion you will be asked whether you consider the overall risk to be low, medium or high.

**2. Action Plan**
On completion of the pro-forma, the risks marked 'H' need to be transferred onto the action plan indicating what action is required and who has responsibility for carrying out that action. The action plan should be reviewed regularly to ensure that those responsible for actions are taking them forward. The advantage in maintaining your action plan is that when you complete the RIP in the following year you will only need to add any new risks identified from that updated document.

**3. Risk Assess**
Where significant risks have been identified, these must be addressed through the risk assessment. In the past managers addressed each hazard individually. Our advice is to address each criterion as a whole, highlighting only those issues of significant risk, ensuring copies are attached to your completed document before returning to the Risk and Safety Team.

**What Happens Next?**
The RIP can be downloaded from the Trust intranet (under 'Forms') completed and returned electronically. The key to managing your audit is to take it in bite-sized chunks, enlisting the help of your staff to cover areas such as medical devices and first aid arrangements.

Once completed, the RIP should be copied and sent to Risk and Safety Team, where the data will be collated and reported to your locality Health and Safety forum and the Trust wide Health and Safety Committee.

The Risk and Safety Team will notify units selected for a visit where an audit of their health and safety arrangements will be carried out.

Well done to Su Burns for being the first manager to complete and return her unit's RIP this year.

If you would like any further help or advice on completion of the RIP please contact me on 01243 815446 or by email: tony.flynn@sussexpartnership.nhs.uk

## Trust Wide Recovery Steering Group

**David Cundy**
**Programme Manager (Exemplar Employer)**

The Trust wide recovery steering group consider how best to develop recovery orientated practice in all care-groups, and professional disciplines, within the trust. The group considers and analyses areas of both internal and external research in order to support the trust in promoting the value of the recovery philosophy in shaping services whilst also delivering improvements to outcomes and quality of the customer's experience. Various projects are currently underway which are led by the recovery steering group and this is an update of the current status.

**Socially Inclusive Practice Evaluation**
The 'Capabilities for Inclusive Practice' (DH, 2007) were developed by the National Social Inclusion Programme (NSIP) to guide best

practice within the mental health workforce. The Trust is committed to the development of a workforce that practices in a socially inclusive manner. Consequently, this project aimed to create and pilot an evaluation tool based on the 'Capabilities for Inclusive Practice' (CfIP). The tool attempted to explore socially inclusive practice and its impact from three perspectives; staff and service user views, and CPA care plan documentation. The pilot testing of the evaluation tool with three teams led to the development of a refined tool and guidance suitable for Trust-wide dissemination. The information was gathered for the various perspectives using a discussion based questionnaire for team perspectives, a self report questionnaire for service user perspectives and an audit of CPA care plans.

The results reported from the pilot were very positive overall with ¾ of service users feeling that they had become more included since working with the team, although many people would also like to be more included than they currently are. Teams were found to be really good at helping service users with housing and benefits, but perhaps could do more to help with education, sports and leisure activities or hobbies. People using services felt that the team respected their strengths and diversity and took account of their goals, but could do a bit more to help them overcome judgment and disapproval from others. They also felt that the main things that stopped them from getting involved in the local community and activities were physical health problems, money problems and issues with confidence.

The results indicate that the teams involved were doing well in achieving socially inclusive practice. This is an area where there has been limited research and it is now important that this is rolled out further across the Trust. The Audit & Effectiveness Team will now be starting to look at mainstreaming this work in other teams in the Trust.

**Peer Support Specialist Training**
**Creating roles for Peer Support Specialists**
A mixed group of service users and staff has completed their training as Peer Support Specialists in April, which was provided by Recovery Innovations (US). The training was aimed at furthering participants' personal recovery and equipping them with the skills required to work as peer support specialists. An evaluation of this training is underway to inform where and under what conditions peer support specialists will be able to work within and outside of the trust. A separate business case will be developed to establish when and how these new roles will be created.

## Care Programme Association (CPAA) Award

**Eva Delves,**
**Audit & Effectiveness Facilitator**
**East Sussex Locality**

In the May bulletin I reported on the excellent recovery work that Sue Buckland and Andy Cable have been doing at Greenwich House, Peacehaven. Sue, with the help of Andy, has been delivering training on how to manage recovery groups with a focus on WRAP (Wellness Recovery Action Plan) since the service they were providing was converted from a conventional day care service to a more structured recovery focused service. They designed a training programme for care-coordinators and service managers whose service was due to undergo this change, or for those interested developing and improving their knowledge in working using WRAP plans. The training programme was designed to educate and share their experience on how to deliver this new way of working.

After publicising their work across the trust through the Report & Learn Bulletin, Sue was nominated for a CPAA 2008 Award. In July, she was awarded a 'Highly Commended Award' in

the 'Excellence in Supporting Recovery' category.

I'd like to take this opportunity to congratulate Sue and Andy for this achievement and hope that they continue to do such excellent and important work and that their efforts continue to be recognised. For more information please contact them on 01273 585750.

## Trust wide CPA Audit

**Eva Delves**
**Audit & Effectiveness Facilitator**
**East Sussex**

The Audit & Effectiveness Team has been conducting a trust wide CPA audit over the last three months. It has been a long process, during which over 1,100 files were audited. I am pleased to report that the Secure and Forensic CMHT at Jupiter House, Chichester demonstrated the best standard of CPA observed across the whole trust. The standard of CPA was excellent and shows that a high standard of work is achievable.

The CPA audit report will be available at the end of August, and we will be sending out posters as a method of communicating our key findings to each team. Our purpose is to share good practice across the trust as we have observed this in many teams, but also to report on the areas that require improvements. We want the results to be viewed as a positive outcome and highlight where improvements need to be made so that everyone can ensure that we are constantly improving the standard of care we deliver.

We would like to thank all the teams who supported us during this audit and made the data collection easy and manageable. Thank you for cooperating with us and making us welcome. If you have any queries with regards to the audit please contact Eva Delves on 01323 440022 ext 3108.

## News from the National Institute for Health and Clinical Excellence (NICE)

**Wendy Harlow**
**NICE and SCIE Implementation Facilitator**

***'Win a NICE shared learning award – share your experience of putting NICE guidance into practice and be in with a chance to win up to £1,500 to support implementation of NICE guidance in the organisation.'***

The NICE Shared Learning Award gives you the chance to share your experience of implementing NICE guidance with colleagues in the NHS and the public health sector. This is your chance to tell us what worked, what didn't work and what you learnt.

Winners will be given a platform to present their work to their peers at the NICE conference. This is an unrivalled opportunity to share your learning and gain recognition for your hard work. Along with the personal and professional satisfaction of winning the award, there is also a £500 prize in each category, with an additional £1,000 for the overall winner, to support implementation projects in your organisation.

The submissions will be judged under three categories: projects covering general implementation systems or approaches; projects focused on implementing specific clinical guidance; and projects focused on getting public health guidance into practice.

The shortlisted candidates will also be offered free and discounted places at the NICE conference.

The closing date for submissions is 30 September 2008.
Last year Sussex Partnership made four submissions and were shortlisted to the final twelve. We know that a great amount of good practice is happening and would like to propose as many projects as possible. Work that includes

user involvement audit and re-audit has a greater chance of success. For more information or support in completing the application please contact Wendy Harlow, NICE & SCIE Implementation Facilitator on 01273 716585 / 07917592984 or email: wendy.harlow@sussexpartnership.nhs.uk

**NICE guidance – Schizophrenia**
The guidance on schizophrenia was the first full clinical guideline published by NICE in 2001. The key recommendations relate to; specialist psychological therapy; medicines management; information; advance directives; vocational assessment; and physical healthcare. The guidance is currently being reviewed by NICE to incorporate new evidence on best practice which has become available. The new guidance is due to be published early in 2009. At the Trust we have recently carried out a baseline assessment of schizophrenia services to gauge what we are currently doing in relation to the recommended good practice in the guidance, where we are doing this particularly well and where potential gaps in services may arise. As a result, and using some of the results of the Healthcare Commission audit of schizophrenia services, we have developed a Trust schizophrenia group who will be taking forward an action plan over the next few months. We will be bringing news of further developments in the next issue of this bulletin. For further information please contact Wendy Harlow, NICE & SCIE Implementation Facilitator on 07917592984 or 01273 716585 or wendy.harlow@sussexpartnership.nhs.uk

## News from the Social Care Institute for Excellence (SCIE)

**Centre for Excellence and outcomes in Children and young people's services (C4EO).**

SCIE is part of the consortium selected as the preferred bidder to run the new C4EO. Commissioned by the Department for Children, Schools and Families, the Centre is due to be launched later in the summer. The core purpose of the C4EO will be to identify, co-ordinate and disseminate national, regional and local knowledge about what works to significantly improve the outcomes for children, young people and families. Its core objectives in doing this will be to:

- Identify where, why and how the lives of children are improving as a result of both the services they and their families receive and the initiatives in a local area to improve outcomes
- Facilitate the bringing together of new partners at local, regional and national level to support a focus on outcomes, analysis of trends and action
- Use local government and its partners to improve and build its own capacity and expertise to share good practice, improving both services and outcomes for children and young people.

We will bring you more news of developments and impact and how this can support and inform the work in CAMHS through transition to adult mental health services as it becomes available.

**New SCIE website**
SCIE has redesigned its website to make it easier for users to find the resources they need. The new look website categorises SCIE's work on adults' and children's and families' services into sub-themes such as mental health and looked-after children, and explains the current work being undertaken in each area.

**Resources**
*e-Learning resources: Poverty, parenting and social exclusion* - These new e-learning resources help people working in health and social care to understand the link between poverty, parenting and social exclusion. The nine training resources include quizzes, videos and case studies of families affected by poverty. The resources are suitable for frontline workers, students and educators.

*Resource guide 11: Children of prisoners - maintaining family ties.* This report brings together resources and research about maintaining family ties for children of prisoners. The findings highlight the negative impact parental imprisonment can have on children, and where to find guidance on developing support services.

All of the resources are free to view, download or order from the website at www.scie.org.uk
For support and help to access the resources or for implementation and audit advice and support please contact Wendy Harlow, NICE & SCIE Implementation Facilitator on 01273716585 / 07917592984 or email: wendy.harlow@sussexpartnership.nhs.uk

## Future Training Dates

**Root Cause Analysis Training**
210 Trust managers have now undertaken the 2 day RCA training programme delivered by Trust facilitators, and the potential demand for courses in 2009 will be audited over the next month. Feedback on how the training will change managers' work practice has been extremely positive, with a sample of their comments below:

*'Will apply tools when incidents arise and take a step back to consider our team's practices as a whole'*

*'May use some of the investigation processes when trying to understand systematic problems both managerially and clinically. Also review policies and ensure staff are aware of them.'*

*'Within my clinical practice the tools will help me identify/discuss working practices which may lead to changes within practice thus reducing SUIs'*

*'I can utilise these RCA tools for other areas of care/service delivery, to identify any potential or actual system failures.'*

The training is appropriate for Band 7 managers upwards and if you, or any or your staff, are involved in investigating SUIs and have not yet attended the programme please take the opportunity to book a place on either of the courses scheduled in September and November 2008:

15 & 16 September 2008 9:00 – 4:00
Sussex Education Centre, Hove

19 & 20 November 2008 9:00 – 4:00
Training Annexe, Woodside, Hellingly

## Putting Audit, Research & NICE/ SCIE Guidelines into Practice

This one day interactive workshop is facilitated by members of the Audit and Effectiveness Team and is open to all clinical and support staff in the Trust. We have received excellent feedback from previous delegates on the usefulness of the course and encourage people to sign up to remaining dates for 2008. These are:

21 October 9:15 – 4:30
Sussex Education Centre, Hove

23 October 9:15 – 4:30
Woodside, Hellingly

To book a place on any of these courses please send or e-mail **(the e-mail must come from your line manager)** a fully completed Training Request form to:
Training Administration Team, Southdown Building, Swandean, West Sussex, BN13 3EP.
Fax: 01903 843036
email: trainingadministrator@sussexpartnership.nhs.uk

**Please note that the Training Administration Team must be in receipt of the TR Form before a place can be reserved and confirmation sent.**

## Latest National Reports/Reviews and Guidance

**Healthcare Commission:**
**'The Pathway to Recovery – A review of NHS acute inpatient mental health services'**
The Healthcare Commission's largest ever review of acute inpatient mental health services was published on 23 July 2008. The Commission assessed all 69 NHS Trusts providing acute inpatient mental health services. For a copy of the report please go to: www.healthcarecommission.org.uk/newsand-events

**Royal College of Psychiatrists**
**'Rethinking risk to others in mental health services'**
The final report of a scoping group was published in June and found that the need to develop a more balanced and responsible approach to the question of risk to others is a matter of immediate importance to the practice of psychiatry and the ultimate safety of the public.

The report highlighted the following principles of risk assessment:

- Accurate risk prediction is never possible at an individual level
- Risk assessment is a vital element in the process of clinical assessment
- Risk assessment informs risk management and there should be a direct follow-through from assessment to management
- The best quality of care can be provided only if there are established links between the needs assessments of service users and risk assessment
- Positive risk management is part of a carefully constructed plan and is a required competence for all mental health practitioners
- Risk management must recognise and promote the patient's strengths and should support recovery
- Risk management requires an organisational strategy as well as competent efforts by individual practitioners
- Risk management needs to recognise the role of other agencies.

In addition to its five key findings, the report made the following recommendations:

- The contribution of substance misuse to risk must be recognised
- The content of discharge letters to GPs should be audited regularly and must include: details of risk to self or others; diagnosis; treatment; indicators of relapse; and the details of any agreed risk management plan
- Risk assessment forms should be evidence based
- A national standard approach is required to risk assessment and should be developed throughout all mental health services
- Working collaboratively with carers and service users to reduce risk

A full copy of the report with detailed findings and recommendations can be found at www.rcpsych.ac.uk

## Have your say

We welcome your comments and feedback on this bulletin and encourage you to use this to share your experiences of learning and improvements. Please contact Denise Caro, Report & Learn Facilitator with any suggestions or articles for publication by email: denise.caro@sussexpartnership.nhs.uk

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