Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 16 April 2015**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr J Bracey	Mr P Balcombe	Broadland District Council
Mrs C Woollard	Ms S Bogelein	Norwich City Council
Mr M Carttiss	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr B Jarvis	North Norfolk District Council
Mr B Bremner	Mrs C Walker	Norfolk County Council
Mr D Harrison	Mr T East	Norfolk County Council
Mr R Bearman	Ms E Morgan	Norfolk County Council
Mr R Kybird	Mr Robert Richmond	Breckland District Council
Dr N Legg	Mr T Blowfield	South Norfolk District Council
Mrs M Somerville	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs S Weymouth	*Vacancy*	Great Yarmouth Borough Council
Mr A Wright	Mrs S Young	King's Lynn and West Norfolk Borough Council

For further details and general enquiries about this Agenda please contact the Committee Administrator:

Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

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1. To receive apologies and details of any substitute members attending

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 26 February 2015. (Page 5)

3. Members to declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter.

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4. **To receive any items of business which the Chairman decides should be considered as a matter of urgency**

5. **Chairman's announcements**

6. **10.10 – 11.15** **Mental health services provided by Norfolk and Suffolk NHS Foundation Trust** (Page 11)

An update report on the implementation of the Trust Service Strategy 2012-16 and the Trust's action in response to the Care Quality Commission inspection report published in February 2015

Appendix A – report presented by Norfolk & Suffolk NHS Foundation Trust (Page 15)

11.15 – 11.25 **Break at the Chairman's discretion**

7. **11.25 – 12.05** **Service in A&E following attempted suicide or self-harm episodes** (Page 65)

A report from the acute hospitals and Norfolk and Suffolk NHS Foundation Trust

Appendix A – Norfolk and Suffolk NHS Foundation Trust (Page 67)
Appendix B – Norfolk and Norwich Hospital (Page 113)
Appendix C – James Paget Hospital (Page 133)

8. **12.05 – 12.15** **Forward work programme**

To consider and agree the forward work programme. (Page 171)

Glossary of Terms and Abbreviations (Page 174)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 8 April 2015

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 26 February 2015

Present:

Mr J Bracey	Broadland District Council
Mr B Bremner	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs M Somerville	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council

Substitute Member Present:
Ms E Morgan for Mr R Bearman, Norfolk County Council
Ms S Bogelein for Mrs C Woollard, Norwich City Council

Also Present:

Matt Broad	Locality Director for Norfolk, Suffolk and Cambridgeshire, East of England Ambulance Service NHS Trust
Mark Burgis	Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group
Chris Cobb	Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust
Sam Revill	Research Manager, Healthwatch Norfolk
David Russell	Member of the public (formerly a member of the LINk ambulance group)
Sharon Roberts	Eastern Regional Manager of Diabetes UK
Suzanne Meredith	Public Health Consultant
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr C Aldred, Mrs A Claussen-Reynolds,

Mr R Bearman, Mr R Kybird, Dr N Legg, Mrs C Woollard and Mr A Wright.

2. Minutes

The minutes of the previous meeting held on 15 January 2015 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

Ms. Elizabeth Morgan declared an "other interest" in that she had been appointed by the County Council to serve on the Norfolk Community Health and Care NHS Trust Council of Governors.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements: Members' visit to Norfolk Constabulary control room

5.1 The Chairman said that Norfolk Constabulary had offered another opportunity to visit the police control room for Members of NHOSC who were unable to attend previously. The visit was to observe the liaison between mental health staff and police in the control room. The potential dates were:-

Thursday 9 April 2015, 10.00am or 2.00pm
Tuesday 14 April, 2.00pm

5.2 The Chairman added that if any more Members of the Committee were interested in visiting this service they should contact Maureen Orr who would circulate the dates by email after this meeting and confirm the one that suited most people.

6 Diabetes Care within Primary Care Services in Norfolk

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from NHS England East Anglia Area Team (EAAT), with input from Norfolk County Council Public Health, on the performance of services commissioned for detection and diagnosis of diabetes and for the long term care of people with diabetes in Norfolk.

6.2 It was noted that the officers of NHS England East Anglia Area Team who were currently responsible for the commissioning of primary care were unable to attend today's meeting and had sent their apologies. They had offered to provide written answers to any questions that the Committee wished to raise with them.

6.3 The Committee received a presentation from Sharon Roberts, Eastern Regional Manager of Diabetes UK, who gave the charity's views about diabetes services in Norfolk. The Committee also heard from Suzanne Meredith, Public Health Consultant, Norfolk County Council who answered questions regarding prevention of diabetes and NHS Health Checks in Norfolk.

6.4 In the course of discussion the following key points were made:

- The detailed presentation that was given by Sharon Roberts, Eastern Regional Manager of Diabetes UK, showed that across the full range of care

processes and treatments included in the Diabetes UK audit, North Norfolk and South Norfolk were the 1st and 2nd best performing areas out of 19 areas in the region. West Norfolk was 7th, Norwich was 11th and Great Yarmouth and Waveney was 19th.

- The Chairman said that Great Yarmouth and Waveney CCG area's apparently poor results in the Diabetes UK 2012-13 audit of target care processes and treatments could be raised at the Great Yarmouth and Waveney Joint Health Scrutiny Committee.
- The witnesses explained the reasons why it was important to increase the uptake of NHS Health Checks for diabetes.
- They said that GPs, and those pharmacists who were registered to give diabetes advice, were able to provide support with lifestyle choice such as how to enjoy healthy foods, how to adjust the diet and how to keep active. Health checks assisted in the detection of any early signs of diabetes so that they could be caught and treated successfully.
- It was suggested by a Member that a high visibility advertising campaign, such as at a football club, might help raise public awareness of the issue.
- The witnesses said that there were a number of risk factors for diabetes, some of which were preventable, such as weight gain around the middle, high cholesterol levels and high blood pressure.
- Losing weight, stopping smoking and reducing alcohol intake could all help to lower the risk of developing type 2 diabetes mellitus.
- In addition to these individual risk factors, certain ethnic communities and people from lower socioeconomic groups were particularly at risk.
- Factors which influenced someone's risk of type 2 diabetes included: weight, waist circumference, and age, lack of physical activity and whether or not they had a family history of type 2 diabetes.
- The witnesses did, however, say that they were unaware of any research into the links between children with diabetes and if their parents had such a condition but would investigate the matter and let Mrs Orr, the Democratic Support and Scrutiny Team Manager, know the outcome.
- Being overweight or obese was said to be the main contributing factor for type 2 diabetes. In addition, having a large waist circumference increased the risk of developing type 2 diabetes.
- Men were at high risk if they had a waist circumference of 37 inches or above. Women were at high risk if they had a waist circumference of 31.5 inches or above.
- The above classification did not apply to some population groups, such as for example, some South Asian adults. For men in this classification there was a high risk if they had a waist circumference of 35 inches.
- The witnesses said that some medications had been shown to lower the risk of type 2 diabetes amongst particularly high-risk cases, such as those with mental health issues, where lifestyles interventions alone might not be enough. There had also been research into emergence of diabetes as a side effect of certain drugs used for psychiatric disorders.

6.5 The Committee **agreed** that information about links between drugs for mental health issues and diabetes should be circulated to Members.

6.6 The Committee also **agreed** that NHS England East Anglia Area Team (the current commissioners of GP services) should to be invited to attend a future meeting to answer Members' questions at the meeting and not in writing.

6.7 In addition, the Committee **agreed** that representatives from the West Norfolk Clinical Commissioning Group area should be invited to that meeting to discuss

their performance in delivering care processes and treatment targets for diabetes in primary care.

7 Ambulance response times and turnaround times at hospitals in Norfolk

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to reports on trends in ambulance response and turnaround times in Norfolk, and the action underway to improve performance. The reports were from the East of England Ambulance Service NHS Trust (EEAST), the N&N as the largest hospital in Norfolk, and the North Norfolk CCG as the lead commissioner of the N&N.

7.2 The Committee received evidence from Matt Broad**,** Locality Director for Norfolk, Suffolk and Cambridgeshire, East of England Ambulance Service NHS Trust (EEAST), Mark Burgis, Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group, Chris Cobb, Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust and Sam Revill, Research Manager, Healthwatch Norfolk. The Committee also head from David Russell, Member of the public (formerly a member of the LINk ambulance group).

7.3 The Committee received an apology for absence from James Elliott**,** Deputy Chief Executive, Norwich Clinical Commissioning Group.

7.4 In the course of discussion the following key points were made:

- The witnesses explained the detailed ambulance response times for Norfolk, set against the agreed trajectories for each CCG, that were included in the report.
- The witnesses also explained performance trends in respect of response times, stroke 60 transport times and turnaround times at the three acute hospitals in Norfolk.
- The witnesses said that EEAST was experiencing high levels of activity. So far this year EEAST had dealt with over 133,000 calls on the 999 service. This was over 6,000 more calls than the commissioned level of activity. This high level of activity had impacted on EEASTs ability to make improvements in its services.
- However, ambulance crew recruitment and training activity was on track and more trainees were now working on the ambulances.
- The witnesses said that as well as increasing the number of ambulance crews EEAST was undertaking a review of its organisational structure to allow for more resources to be transferred to front line services. The review included the introduction of new technology at EEAST's headquarters to help run its operational services.
- Throughout 2014/2015 there had been an unprecedented rise in the demand for A&E services.
- Ambulance arrivals at A&E at the NNUH were currently showing an increase of 8% on the same period in 2013/14.
- The NNUH planned to take on 9 additional junior doctors in a staged approach with 5 to be recruited this year and 4 next year.
- The witnesses said that when ambulance handover delays occurred at the NNUH it was usually as a consequence of reduced flow throughout the hospital and/or a significantly higher than expected demand on the emergency admission areas.
- All the health and social care agencies in Norfolk relied on each other and worked together closely to resolve the issue of ambulance delays at

hospitals.

- Members said that some of the issues concerning ambulance response times appeared to relate to capacity issues at the NNUH.
- Norfolk was geographically challenging for ambulance crews in terms of the county's rural isolation, its road conditions and its elderly population.
- As the geographical conditions in Norfolk were in many ways different from those elsewhere in East Anglia, a Member suggested that ambulance response times might be improved if the county was served by a purely Norfolk Ambulance Service rather than by an East Anglia Ambulance Service.
- The witnesses said during January 2015 there had been no breaches in agreed Red 1 ambulance back up response times and only two breaches of agreed Red 2 back up response times.
- The Red 1 and Red 2 call standards were reported to the Commissioners on a simple pass / fail basis that did not reflect the length of time that a 'failed' response actually took.
- It was pointed out that the Norfolk 111 Service was amongst the top ten performing 111 Services in the country.
- The Committee was informed of the success of the measures included in Project Domino (in the central Norfolk area) together with other commissioning actions to encourage better ambulance response times and turnaround performance.
- Sam Revill, Research Manager, Healthwatch Norfolk, said that research undertaken by Healthwatch Norfolk showed that the public valued the service provided by EEAST. This research indicated that there was a 90% public satisfaction rate with the ambulance service; those who were dissatisfied with the service were mostly concerned about the time that it took for an ambulance to arrive at their home, or about the transfer from the ambulance to the hospital, rather than the service that was provided by ambulance crews.
- David Russell, a Member of the public (formerly a member of the LINk ambulance group), said that EEAST had in his opinion successfully introduced a team of staff known as Hospital Ambulance Liaison Officers (HALO) to support both EEAST and the NNUH in the turnaround of crews as quickly, efficiently and as safely as possible. In reply it was pointed out by the witnesses that the NNUH were entirely supportive of the HALO role, which was funded by winter funding monies only. EEAST had worked in close conjunction with the NNUH and senior trust management to ensure the HALO role developed and became an integrated role for both organisations.
- Mr Russell questioned the lack of information that was available regarding the fines paid by EEAST for breach of contract in relation to ambulance response times and handover times and suggested that this was something that the Committee might wish to pursue.

7.5 It was **agreed** that the Commissioners and East of England Ambulance Service NHS Trust (EEAST) should be asked to provide the following additional information:-

1. How much have EEAST and the acute hospitals in Norfolk paid in penalty fines for breach of contract in relation to ambulance response times and handover times?
2. Which Commissioners have levied the contract penalty fines?
3. What have the Commissioners done with the money that has been paid in fines by EEAST and the acute hospitals in this context?

7.6 The Committee **agreed** that this information should be provided in written reports as soon as convenient and would return to the subject in 12 months' time.

8 Forward work programme

8.1 It was **agreed** to appoint Mrs Margaret Somerville as substitute NHOSC link member for Norwich Clinical Commissioning Group.

8.2 The proposed forward work programme was **agreed** with the following changes:-

'Diabetes care within primary care services in Norfolk' – to be added to the forward work programme for 28 May 2015. NHS England East Anglia Area Team and West Norfolk Clinical Commissioning Group to be invited to attend.

'Ambulance response times and turnaround times in hospitals in Norfolk' to be added to the agenda for February 2016 NHOSC

Chairman

The meeting concluded at 1 pm

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Mental health services provided by Norfolk and Suffolk NHS Foundation Trust

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

An update from Norfolk and Suffolk NHS Foundation Trust (NSFT) on the effects of changes to services in the 2012-16 Service Strategy and action to address the findings of the Care Quality Commission's latest inspection report.

1. Background

1.1 Early in 2013 Norfolk Health Overview and Scrutiny Committee (NHOSC) and Suffolk Health Scrutiny Committee established a formal joint committee on a task and finish basis to examine the radical redesign of mental health services outlined in NSFT's Trust Service Strategy 2012 - 16. The joint committee's report, which presented to NHOSC on 20 June 2013, made recommendations to NSFT, the Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards. NSFT was recommended to:-

- Only proceed with reconfiguration plans that have the commissioners' backing.
- Closely monitor its workforce costs during the transitional period and consider how to avoid excessive locum costs.
- Consult with health scrutiny before making substantial changes 'on the ground' during the implementation of the Strategy. (This was to be done in liaison with the relevant CCG and it was expected that CCGs would take the lead).
- Include the Healthwatch organisations in Norfolk and Suffolk and other representatives of service users and carers in its ongoing involvement / engagement process and in the development of consultation materials in respect of major changes.
- Work with the GP practices, CCGs and other stakeholders on the issue of whether the Norfolk or Suffolk service model should apply to Thetford in future years.
- Assess the likely effects of its plans on partner organisations and monitor the effects throughout the transition period to avoid gaps in service.

1.2 Subsequent to the 2013 joint committee, which ended before the County Council elections in May 2013, the health scrutiny committees in Norfolk and Suffolk have monitored NSFT's progress separately, except for the

Great Yarmouth and Waveney area for which there is a standing joint health scrutiny committee.

1.3 **Great Yarmouth and Waveney** CCG carried out full public consultation on changes to adult and dementia mental health services in its area and consulted with the Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC). The plans for the area included a reduction of acute mental health beds from 28 to 20 and the closure of 12 dementia beds. This was to happen alongside the development of community mental health services to support people at home and was also linked to the provision of 10 additional acute mental health beds in Norwich (NSFT now intends to provide 12 additional beds in Norwich, Thurne ward). Information and resource centres were also to be established in Great Yarmouth and Waveney and the joint committee was informed that there would be new services at Carlton Court in Lowestoft, which could include beds and services for younger people.

On 8 October 2014 the joint committee agreed that:-

(a) It was satisfied that the consultation on the proposals had been adequate in relation to content and time allowed; and
(b) It was satisfied that the CCG's final proposals were in the interests of the health service in its area.

1.4 In **central Norfolk**, where no bed closures were proposed, the changes to mental health services were not considered to amount to a substantial variation on which formal consultation with health scrutiny is necessary. Nevertheless the central Norfolk CCGs (Norwich, North Norfolk and South Norfolk) and NSFT have provided several updates to NHOSC on developments in their area, with the most recent on 4 September 2014. There has been significant pressure on adult acute beds in central Norfolk, with high levels of out-of-area placements.

1.5 In **west Norfolk**, where the permanent closure of acute dementia beds is proposed, it is considered that the changes are a substantial variation on which consultation with health scrutiny is necessary. However, the approach in west Norfolk has been to stop using some of the beds (Tennyson and Chase wards at Chatterton House) on a trial basis while at the same time establishing a Dementia Intensive Support Team to provide much more extensive support in the community obviating the need for beds. NHOSC was assured that all beds taken out of the system on a trial basis would remain available for use if needed and that the committee would be consulted before any decisions on permanent substantial changes were taken. NHOSC received an update from NSFT and the CCG on 4 September 2014 and the CCG is expected to launch public consultation in June 2015.

2. Purpose of today's meeting

2.1 On 15 January 2015 NHOSC was informed of concerns about NSFT's service raised by the County Council Member Champion for Mental Health and other members. The committee agreed to ask NSFT to

report to today's meeting on the situation regarding out of area placement of mental health patients and the overall effects of the changes introduced under the Trust Service Strategy 2012-16

Bearing in mind that changes in one Norfolk locality can affect patients from other Norfolk localities (e.g. patients being place further from home if bed capacity in their locality is insufficient), NSFT has been asked to report on its services across Norfolk.

2.2 On 3 February 2015 the Care Quality Commission (CQC) released the report of its latest inspection of NSFT's services, which were given an overall rating of 'inadequate'. Details of the report were included in NHOSC's 26 February 2015 Briefing. The Trust has been placed in 'special measures' and an Improvement Director, Mr Alan Yates, has been appointed by Monitor to work with the Board.

NSFT has been asked to update NHOSC on action underway to address the findings of the CQC report.

Mr Michael Scott, Chief Executive of NSFT, has been invited to attend today's meeting and the Trust's report, which was compiled with input from Norfolk County Council Adult Social Care and Norfolk Constabulary, is attached at Appendix A. The partners who were involved in producing the report have also been invited to attend today's meeting.

3. Suggested approach

3.1 After Mr Scott has presented the NSFT report, members may wish to discuss the following areas:-

(a) Twelve additional short stay assessment beds in central Norfolk (Thurne ward) are being opened on a gradual basis, with six open in March 2015. When does NSFT expect the remaining six to be open and fully operational?

(b) The new centralised Access and Assessment service, which was a significant part of the 2012-16 Trust Service Strategy is to be decentralised by June 2015. How confident is NSFT that decentralisation will lead to a decrease in demand?

(c) What is the current average waiting time for the adult community service in each of the Norfolk localities?

(d) The radical redesign in the 2012-16 Trust Service Strategy was considered necessary to address NSFT's financial situation. Given the significant change in strategy will the Trust be able to deliver necessary savings?

(e) Given the current steep rise in demand and the decline in NSFT funding in the years to 2013-14, shown in the graph in Appendix 5,

does NSFT consider that it is possible to adequately address the actions required by the CQC report within current CCG funding?

(f) What additional steps have been taken to improve staff morale following the CQC report?

(g) Given the need to increase staffing levels to maintain safe services and the current national workforce shortages, is the Trust able to recruit permanent staff or does it expect the bill for locums and agency staff to rise?

(h) Has agreement been reached regarding the future model for mental health services in Thetford? (i.e. whether they will operate under the Norfolk or Suffolk model).

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Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Norfolk Health Overview and Scrutiny Committee
Meeting Date:	Thursday 16th April 2015
Title of Report:	NSFT Report to the NHOSC (v1.4)
Action Sought:	For Information
Estimated time:	20 minutes
Author / compiler:	Marcus Hayward, Locality Operations Manager, NSFT
Contributions from:	Debbie White; Veno Sunghuttee; Micki Munro; Gill Aspinall; Jenny Wright; Karen Wheeler; Amy Eagle; Denise Braitsch; Maureen Begley (NCC); Amanda Ellis (Police).
Director:	Michael Scott, Chief Executive, NSFT

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Executive Summary

- Overall referrals to NSFT services in Norfolk and Waveney (via Access & Assessment) have continued to increase throughout 2014/15 with 38% more referrals in the 3 months from December to February than in the first 3 months from April to June. This varies from a rise of 18% in Great Yarmouth and Waveney to an increase of 48% in Central and West Norfolk.
- This increase in referrals is putting pressure on community services and resulting in higher caseload levels, waiting times and the unallocated caseload.
- The high referral rate has also reduced capacity to provide ongoing monitoring and crises prevention, which is a contributory factor to the pressure on beds.
- Despite this increase in demand on NSFT services (Appendix 5, i) funding for the Trust has continued to decline (Appendix 5, ii).
- Urgent remedial actions are underway and including:
  - Recruiting to additional posts in Adult Community Services and including a new Flexible Assertive Community Treatment (FACT) function specifically targeted at crises prevention;
  - Reviewing the Access and Assessment function in Central and West Norfolk with plan to reintegrate within Localities and closer to primary care.
- Pressure on inpatient beds peaked in October 2014 with 52 patients in our of Trust beds. However, concerted action has seen this number reducing to a total of 21 placed out of Trust in January and further reduction in February.
- Central Norfolk has seen the greatest disparity of demand over available beds. This is being addressed with the addition of Thurne Ward, which when fully operational will provide an additional 12 short stay assessment beds that will help reduce overall lengths of stay.
- The first patients were admitted to Thurne Ward in March with gradual opening of the 12 beds as the staffing levels reach full establishment.
- There have been important ongoing developments during 2014 including establishing mental health practitioner presence in the Police Control Room and ensuring mental health liaison services are available to the A&E departments at the NNUH and QEH.
- Close scrutiny is being maintained on all aspects of service delivery through a wide range of reporting matrices and key performance indicators. Weekly, monthly and quarterly reports are produced including dashboards and performance or thematic analysis. These are shared were applicable with commissioners and other monitoring organisations.
- Following the Care Quality Commission visit to NSFT in October 2014, there has been a major review of Quality and Governance arrangements and a comprehensive Quality Improvement Plan has been approved by the NSFT board in March and shared with the CQC. This is now being incorporated into locality action plans and progress will be monitored at both Locality and Trust level.

Introduction to report structure

The NHOSC information requests and questions are detailed in italic text in sections 1.0 to 9.0. The corresponding sub-numbed sections provide NSFT's responses and includes information provided by partner organisations where relevant.

Section 10 provides NSFT's response to the request for information about self-harm presentations within our local A&E departments. Although a separate NHOSC agenda item, this is included in this report for completeness of NSFT's response to all requests for information. **NOTE - section 10 has been moved to agenda item 7, appendix D.**

Appendix 1 to 9 provides further details, tables graphs and documents referenced within the body of this report. **Appendix 9 moved to item 7, appendix D**

1.0 *Information on out of area placement of mental health patients (i.e. in acute mental health beds outside Norfolk & Suffolk)*

Please give monthly figures from April 2014 to date and include:-

- *How many of those people admitted out of area have parental responsibility for a child or children aged under 18?*
- *How many of those placed out of area are an identified carer (e.g. for a disabled adult or elderly parent)*
- *Locations to which out of area patients have been sent.*

1.1 Appendix 1, table 1, provides a trend of the number of patients in out of area beds as reported weekly on Thursdays from 3rd April 2014 (showing recent status up to 19th March 2015). This shows the number of patients in out of area beds peaked at 44 on 6th November (week 32). There has been a marked downward trend since then with the lowest recorded number of 6 patients in out of area beds on 26th February (week 48).

1.2 Of the 270 placed out of area between April and January, the status of parental responsibility was recorded in 240 cases (89%). Of these 47 (17%) had parental responsibility. (Appendix 1, table 2)

1.3 The status of other caring responsibility was recorded in 242 cases (89%). Of these 2 (1%) had carer responsibility. (Appendix 1, table 3)

1.4 Appendix 1, table 4, provides details of the locations used for the 270 out of area placements, including NHS and private providers.

1.5
- We are committed to reducing out of area placements to only those patients requiring specialist care that we do not have provision for within our current contracted services.
- We conduct a weekly multi-agency Delayed Transfer of Care (DETOC) meeting, with representation from commission and social services, which scrutinises all potential and actual delayed transfer of care inpatients to ensure actions are being taken to address the causes.
- We also have a weekly bed state meeting to scrutinise inpatient activity by ward with representation from all localities. This meeting is informed by weekly bed status reports that are also shared with each of the Norfolk CCGs (Appendix 2, i).

- There is also a weekly Acute Dashboard that also informs the bed state meetings (Appendix 2 ii).
- Since the peak of out of area placements in October, experienced and senior clinicians, including from within the Trust's bed management team, have been providing extra support to Localities. This has included visiting out of area placements to undertake reviews and ensure that discharge or transfer to a Trust bed is enabled at the earliest opportunity.
- Thurne Ward, providing a 12 bedded short-stay assessment function for Central Norfolk and announced at a previous NHOSC meeting, commences operation during March 2015. This is expected to improve the capacity of Central Norfolk to manage within the available beds at Hellesdon Hospital.
- The beds on Thurne Ward are being opened gradually as staffing levels reach full establishment. 6 beds are in use as at end March.

2.0 *Information on 'internally displaced' mental health patients (i.e. in acute mental health beds within Norfolk and Suffolk but not within their own locality)*

Please give monthly figures from the start of radical redesign to date and include:-

- *How many of those people admitted out of locality have parental responsibility for a child or children aged under 18?*
- *How many of those placed out of locality are an identified carer (e.g. for a disabled adult or elderly parent)*
- *Localities that patients are from and the localities to which they have been sent.*

2.1 During the period from April 2014 to January 2015 a total of 180 patients have been placed in an NSFT bed outside their CCG area of residence with a range from 12 to 28 in any one month (Appendix 3, table 1)

2.2 Of the 180 patients placed in NSFT beds outside their CCG area of residence (internally displaced) the status of parental responsibility was recorded in 169 cases (94%). Of these, 36 (20%) had parental responsibility. (Appendix 3, table 2)

2.3 The status of other caring responsibility was recorded in 172 cases (96%). Of these 2 (1%) had carer responsibility. (Appendix 3, table 3)

2.4
- We strive whenever possible to admit a patient to a bed within their own locality / CCG area of residence.
- Once operational it is anticipated that Thurne Ward will result in a reduction in the number of patients being internally displaced into beds in GYW and West Norfolk. This will enable those localities to better manage the acute needs of the local population they serve within their available local bed capacity.
- However, it is essential that the total bed stock in Norfolk and Waveney is used flexibly to meet the acute needs of the resident adult population. Admission to out of locality area beds will continue to occur if the alternative would be admission out of area.

3.0 *Information on the numbers of community patients awaiting the allocation of a lead care professional or care co-ordinator, i.e. unallocated cases. Please give monthly figures from April 2014 to date and include 'team held' cases where patients have not been allocated a named professional.*

3.1 Appendix 4 contains waiting list caseload numbers from April to January.

In January 2015, the numbers as follows, including as a proportion of the total caseload:

Service Line	Actual Caseload	Waiting #	Waiting %
Children, Families & Young People (CFYP):	3631	260	7.1%
Adult Community	4840	563	11.6%
Dementia & Complexity in Later Life (DCLL):	3027	129	4.3%
Total:	11,498	952	8.3%

Unallocated cases in the Adult Community and CFYP Service Lines represent the actual waiting list, as new referrals are not allocated to Mental Health Practitioners (MHPs) in the role of Lead Care Professional (LCP) or Care Coordinator (CC) until they have capacity to commence care planning.

Caseloads in the CFYP Service Line, including the number waiting, are not a cause of concern as within acceptable operational tolerances.

The number of cases waiting in the Adult Community Service in West Norfolk (174 as at January) is a true reflection of the current pressures in that locality.

Unallocated cases reported for Adult Community Services in the Central Locality (196 as at January) include a proportion that although not allocated to an LCP or CC, are not actually waiting for commencement of service for the following reasons:

- Stable patients on s117 only requiring 6 monthly reviews. A new team will be created under Lorenzo for these service users and removing them from the unallocated numbers.
- Patients who are awaiting completion of the administrative discharge process. Work is underway to clear any backlog.
- Patients referred for ADHD assessment / treatment. These patients are on a waiting list for commencement of a dedicated service agreed with commissioners. (This service is expected to become operational in 2015/16 Q1.)
- Stable long term Clozaril patients. These service users have regular contact when attending for prescriptions and blood tests, and will be allocated to caseloads when team capacity increases.
- A small number of patients in the South with social care needs alongside some health needs but assessed as low risk who were previously care coordinator by social care staff (pre-s75 change in Oct 14). These patients are waiting re-allocation to NSFT MHPs when team capacity increase.
- Service users not allocated to a LCP or CC, but who are having face to face contact with a support worker or other clinician.

3.2 Remedial actions: Adult Community Service Line

Actions to mitigate risks and reduce waiting list:

- Funding for a further 14 WTE Mental Health Practitioner posts across Central and West Norfolk has been agreed with commissioners and active recruitment to these posts is underway.
- Recruitment has been progressing well in the Central Locality and it is anticipated that 9 newly appointed MHPs will have been recruited by end April 2015, providing increased caseload capacity for in the region of 200-250 service users.
- Vacancies of band 5 and 6 MHPs are being covered by bank and agency staff wherever suitably experienced practitioners are available.
- A major factor resulting in the caseload pressure in Central and West Norfolk is that the rate of referrals is greater than expected levels based on historical trends, with referrals in the period Dec to Feb, 138% higher than April to June.
- However, in GYW referral rates are closer to predicted levels (with the increase only 18%), and it is notable that the Access and Assessment function remained within the Locality and more integrated with primary care and Adult Community services.
- In Central and West Norfolk the Access and Assessment function was centralised in 2013, and the evidence now suggests that this has inadvertently contributed to an upward trend in referrals exceeding expectations (Appendix 5, i). Plans are now underway for the return of Access and Assessment to Central and West Localities in June 2015, enabling better integration of this function within the Localities and closer to primary care. Meetings with GPs commenced in February about how best to provide this service locally. It is expected that this change will result in a reduced referral demand through providing improved support and responsiveness to primary care.

In addition to these actions, the following risk management actions are being taken within Localities to manage risks in those awaiting allocation to a caseload:

- When first referred, service users receive a letter providing a contact phone number for telephone support.
- Clinical team leaders closely monitor caseloads, with updated lists provided by the clinical admin teams. This includes RAG rating referrals with those rated as 'Red' being prioritised for allocation to a caseload and prompt telephone support when necessary.
- Contacts service users waiting to be allocated and those causing concern are discussed at clinical team meetings with priority changing if needs or risks change. Further action is then taken on a case by case basis as considered necessary.
- Each clinical team now has a daily duty worker whose role it is to respond to contact by a service user who are unallocated or where the lead care professional or care coordinator is not available.
- We are currently introducing the Flexible Assertive Community Treatment (FACT) model throughout Norfolk and Waveney. This is an internationally recognised approach providing increased capacity within community teams to respond to service users pre-crisis to provide enhanced levels of support when needed.

- FACT has been in place in Gt Yarmouth and Waveney since 1st October 2014 and has reduced demand on CRHT and the acute pathway. FACT recruitment is underway in Central and West Norfolk.
- The wellbeing services are regularly reviewing patients on the waiting list for suitability for treatment from their service and instigating contact when appropriate.

3.3 DCLL Service Line

Average waiting time from referral to first assessment contact, rather than unallocated caseload numbers, are the best measure of pressure within the DCLL Service Line, were about 80% of the referrals are for the memory assessment and dementia treatment pathway. Referrals are allocated to practitioners soon after they are first received. This enables an assessment appointment to be scheduled soon after referral.

As at January 2015, the average waiting times within the DCLL Service Line by Locality: GYW: 29 days; Central: 31 days; West: 36 days.

While average waiting times are outside the Trust's target of 28 days, this currently still enables treatment to commence well within the 18 weeks referral to treatment target applied to Acute Trusts.

4.0 *The effect of changes to mental health services on support for homeless people.*

The NNUH / Norwich City Council Hospital Discharge and Homeless Prevention Protocol says 'Patients affected by severe and enduring mental health conditions will not be accommodated by the Council(s) without due consideration of the suitability of proposed care package, which includes a risk management plan, and the type of accommodation available'. Please inform the committee about NSFT's role in relation to this protocol and any similar protocols with the JPUH & QEH.

A City Councillor has heard that there is no longer a full support programme in place for homeless people with mental health issues and that they are consequently going through the system several times. Please provide information on what has changed in relation to homeless people.

4.1 Those referred with no fixed abode (NFA) have the same mental health assessment and treatment service as those who do have a permanent place of residence.

4.2 The Norwich Homeless Team was integrated with Adult Community Services during the Trust Service Strategy process. All service users who would have been referred to that team are now seen within the Community services.

4.3 Information provided by NCC states:

"Norfolk county council commissions specialist mental health floating support through Together which helps people keep their accommodation, deal with debts and benefits, and helps people who are homeless be rehoused.

We fund Highwater House care home for people with dual diagnosis and who often have a history of homelessness.

We fund the St Martins Housing resettlement team which works with people with mental health needs who have a history of homelessness.

A new project on Help for Single Homeless is starting up and NSFT will be a partner agency in this initiative."

5.0 *The effect of the changes to mental health services on policing.*
Please provide:-

- *Monthly figures from April 2014 on the number of people detained under section 136 of the Mental Health Act 1983 who are taken to police cells and the average length of time they are detained there.*
- *An update on the effect of having mental health workers in the police control room.*

5.1 From April to December 2014 there were 273 section 136 detentions across Norfolk & Waveney with an average of 30 per month. However, there has been a marked downward trend in referrals since the peak in September of 41 (Appendix 6, table 1).

5.2 Of 39 detentions in Q3 where the start and finish times are accessible: 7 (18%) concluded within 3 hours; 19 (49%) were between 3 and 6 hours; 4 (10%) between 6 and 9 hours; and 9 (23%) over 9 hours (Appendix 6, table 2).

The reason for the increase in the proportion waiting over 9 hours was the unusual pressure on beds in Q3, peaking in early November (see Appendix 1, table 1), and delays in finding and arranging conveyance to a suitable bed.

5.3 <u>Mental health practitioners in the Police Control Room (PCR)</u>

- Funded until March 2016 (Home Office Innovation Funds, OPCC, Norfolk Constabulary & NSFT)
- Supervisor and three band 6 mental health professionals providing daily cover from 08:00 to 22:00, providing specific information and advice where a person is known to services and generic advice where they are not
- Impacting on three broad call types:
  - Critical incidents (sec 136 use, missing persons, negotiator situations, firearms incidents)
  - Non-critical calls (undiagnosed dementia sufferers for example)
  - Repeat Demand (joint problem solving)
- Full academic Evaluation (UEA) running from End October 2014 for 1 year. Interim report due July 2015, full report due November 2015.
- Broad benefits:
  - The individual (appropriate and timely response)
  - Police (timely and appropriate advice with more effective risk assessments & demand reduction)
  - NSFT (demand reduction, prevention of repeat admissions and crises prevention)
  - Health (early recognition and diagnosis of dementia)
  - All (more effective management of repeat demand)
- From end October 2014 to end February 2015:
  - Over 1700 recorded 'contacts' by the team
  - 70 incidents where the police have not had to attend as a result of information / advice from the team

- 26 occasions where s136 use was averted
- 39 referrals made to GP's
- 113 home joint home visits (supervisor only)
- 128 Dementia related contacts
- 477 contacts with repeat callers

5.4 The most recent Section 136 Quarterly report provided by Norfolk Police (for Q3), provides further commentary on the positive benefits of MHPs in the PCR:

> "Data from this period, when compared to the previous quarter, reveals a 59.42% decrease in the number of s136 detentions. This is a marked decrease from the last quarter which was 16.21%. In the past, s136 detentions were averaging one a day. Figures for November and December 2014 show a dramatic reduction to 18 and 19 cases each month respectively...
>
> The percentage of individuals who were taken to a PIC as an initial Place of Safety has continued to show a decrease. This remains low compared to national data."

The report concludes with reference to the new PCR mental health provision:

> "The introduction of the Mental Health team into the Norfolk Constabulary Control Room continues to have a positive impact in terms of reducing the number of s136 detentions. The reduction shown in this quarter can in part be attributed to the MH partnership team which has averted a number of potential s136 detentions."

6.0 *Disparity in the services available to mental health patients in different localities*

Councillors are aware that some services are not available in certain areas (the example given was support for parent / child attachment, not available in west Norfolk but available elsewhere).

6.1 Core contracted services are standardised across Norfolk and Waveney within the 5 services lines: Improving Access to Psychological therapies (IAPT); Access and Assessment (AAT); Children, Families and Young People (CFYP); Adult Community and Dementia and Complexity in Later Life (DCLL).

There may be variations in *how* the services are provided within a locality that take account of the local needs, demographics and geography, but this does not impact on *what* is provided.

6.2 There are also NSFT services available to Norfolk and Waveney but hosted within specific localities. Examples being: Psychiatric Intensive Care and Low Secure Units at Hellesdon Hospital; Assessment beds for Dementia and Complexity in Later Life hosted at the Julian Hospital, Continuing Care beds at the Julian Hospital and Carlton Court; and the CAMHS Tier 4 unit in Lothingland, Lowestoft.

6.3 There is an initiative underway called the *Norfolk Parent Infant Attachment Project* which is funded via the department for communities grant in partnership with NCC. This is a fully integrated project with children's services and clinical leads from NSFT. The project will run for 12 months with pilot sites in West Norfolk, Central and Great Yarmouth.

Norfolk has a high number of looked after children and the aim of this project is to divert children from becoming looked after by focussing on parent-infant attachment issues, parent mental health, etc.

7.0 *The numbers of adults in mental health residential care establishments in Norfolk compared to other parts of England*

One of the councillors understands that there are more than 400 in residential care in Norfolk, which is a high number compared to other similar counties.

7.1 The following table shows the number of adults in mental health residential care placements in Norfolk by NCC Locality, as at 10th February 2015:

NCC Locality	Total
West	38
North	97
Norwich	93
South	44
East	56
Other	15
Total	343

* Carrow Hill residents + Out of County

7.2 All people placed into residential care receive regular reviews involving partner agencies when applicable. These reviews always question the ongoing appropriateness of the placement and what alternative options may be available.

8.0 *The levels of caseloads for NSFT staff.*

Please provide monthly average caseload numbers in each of the localities from April 2014.

8.1 Appendix 7 shows average caseloads per non-medical registered practitioner from April 2014 to January 2015 by Service Line and Locality.

The average caseload over this 10 month period as follows:

Locality	CFYP	Adult	DCLL
GYW	27	45	47
Central	25	39	44
West	25	43	52

8.2 Caseload numbers continue to be closely monitored and actions implemented to address where the numbers exceed safe levels (see also section 3.2).

9.0 *Performance monitoring of the overall effects of the changes to mental health services.*

Please provide an update on the performance measures that were set for 2012-16 Service Strategy (copy of the quality & safety measures given to the Norfolk & Suffolk Joint Committee on Radical Redesign of Mental Health Services attached).

9.1 The performance indicators within the 2012 to 2016 Quality and Safety Measures are as follows (grouped with commentary):

9.2 **Service demand** - number of referrals, number of 4 hour, 72 hour and 28 day assessments and number of service line registered cases against % expected (daily reports)

Triage including risk assessment - time to triage new referrals (% completed in one working day)

Waiting time for assessment - number of 4 hour, 72 hour and 28 day assessments completed within standard time

Waiting time for treatment - waiting time for activation of care package following assessment (% completed within a standard to be agreed)

How monitored

AAT performance reports are provided monthly. The February report is provided in Appendix 8, i.

This shows the number of 4 hour, 72 hour and standard 28 day referrals and performance in meeting these times.

Average waiting for treatment times are captured within the monthly community status reports shared with commissioners (Appendix 8, ii).

Commentary

- Referrals to Access & Assessment teams in Norfolk and Waveney, in February 2015, were 2,521. This represents an increase of 37% compared to the 1,845 referrals received in February 2014.
- Appendix 5, i, shows the number of referrals by month including trend lines in 2014/15. This shows a referral trend in Central and West Norfolk well in excess of that in Great Yarmouth and Waveney. This was an important factor in the decision to return the Access & Assessment function to Localities in Central and West Norfolk (see also section 3.2).

9.3 **Inpatient capacity** - maximum wait (measured in minutes) for allocation of bed during a Mental Health Act Assessment

Inpatient capacity - service users admitted to adult acute inpatient unit out of designated locality area

Inpatient capacity - bed occupancy excluding and including leave

Home treatment availability - % admissions with access to CRHT

How monitored

The AMHP Service in Norfolk is provided by Norfolk County Council and regular reports are provided and the Police maintain and report on s136 and other mental health assessments in police custody.

Inpatient activity is being monitored by the weekly bed status report. See Appendix 2, which is further scrutinised at the weekly bed status meeting.

Commentary

- Following concerns about the waiting times in s136 suites (see also Appendix 6, table 2) we are currently recruiting extra staff to ensure mental health staff are able to attend s136 suites within an hour of police arriving with the service user. This will be subject to performance monitoring.
- See also comments provided in section 1.5 above.
- We are continuing to work with partner organisation and commissioners to address the high admission rates in Norfolk and evaluating projects aimed at reducing the need to admit to an acute mental health bed by providing viable alternative to admission solutions, including block purchased care home beds for people with dementia.

9.4 **Community safety** - % of service users followed up within seven days following discharge

How monitored

This indicator is a monitor target (QU01) with a 95% performance target. This Key Performance Indicator, along with a range of other performance targets are scrutinised via internal monthly Performance Review Groups, and action plans required whenever performance falls.

Commentary

- We recognise the importance of making contact with service users following discharge from inpatients wards due to this period being known to carry increased risks.
- The Trust routinely achieves 100% and robust action is taken whenever there is evidence of 7-day follow up performance falling below full compliance.

9.5 **Serious Incidents** - number of Serious Incidents by Locality and Service Line (categorised, e.g. unexpected death, data breach)

Complaints - by Locality and Service Line (categorised)

How monitored

These indicators are monitored via monthly Locality Governance Meetings, the Trust wide Quality Governance Committee (Board sub-Committee) and monthly Clinical Quality Review Meetings (CQRM) with commissioners.

Commentary

- Reports and or performance dashboards are submitted to these meetings monthly and or quarterly and are scrutinised closely to ensure themes and trends are identified and appropriate remedial actions taken as necessary. (Appendix 8, iii-vi).

9.6 **Staffing levels** - vacancy rate, sickness absence rate, temporary staffing rate; by Locality and Service Line.

How monitored

This indicator is also monitored via monthly Locality Governance and Performance Review Group Meetings, the Trust wide Quality Governance Committee (Board sub-Committee) and the monthly Clinical Quality Review Meetings (CQRM) with commissioners. There are also monthly meetings with NHS Professionals to review temporary staffing activity and address areas of concern (e.g. shift fill rate performance).

Commentary

- A workforce performance dashboard is produced monthly providing the Trust figures by Locality and County. February performance in Norfolk as follows: Sickness Absence (5.23%), Turnover Rate (15.59%), Vacancy Rate (7.97%), Staff Appraisals (69.76%) and Mandatory training (67.18%). (Appendix 8, vi).
- Benchmarking data with other mental health trusts shows our sickness levels are now the 18th best in the country and below average for the region.
- Temporary staffing usage is also closely monitored by finance and reported on a monthly basis. In February, the proportion of temporary staff as follows: Central Locality, 12%; West Norfolk, 7%; GYW, 14%. Overall, 11%. Temp staff proportion in Central and West has fallen by 3% since start of 14/15; however, in GYW, it has increased by 5%, impacted by the public consolation about changes to mental health services on the coast and the increase in vacancies in those services planned for closure.
- Safe staffing levels have been reviewed in all inpatient units and staffing numbers and skills mix adjusted accordingly.
- An electronic roster system is being introduced in all inpatient units and will provide real time information about staffing levels and pressures at any given point.

9.7 The documents referenced in this section, together with the embedded documents provided in the Appendix 2 and 8, are by no means exhaustive. There are a range of other reporting metrics (e.g. Mental Health Cluster activity) that are also reported to commissioners and when applicable other monitoring organisations on a regular basis.

9.8 Following the Care Quality Commission visit to NSFT in October 2014, there has been a major review of Quality and Governance arrangements within NSFT and a comprehensive Quality Improvement Plan approved by the NSFT board in March and shared with the CQC. This is now being incorporated into locality action plans and progress will be monitored at both Locality and Trust level.

NSFT Report to the NHOSC (v1.4) – April 2015

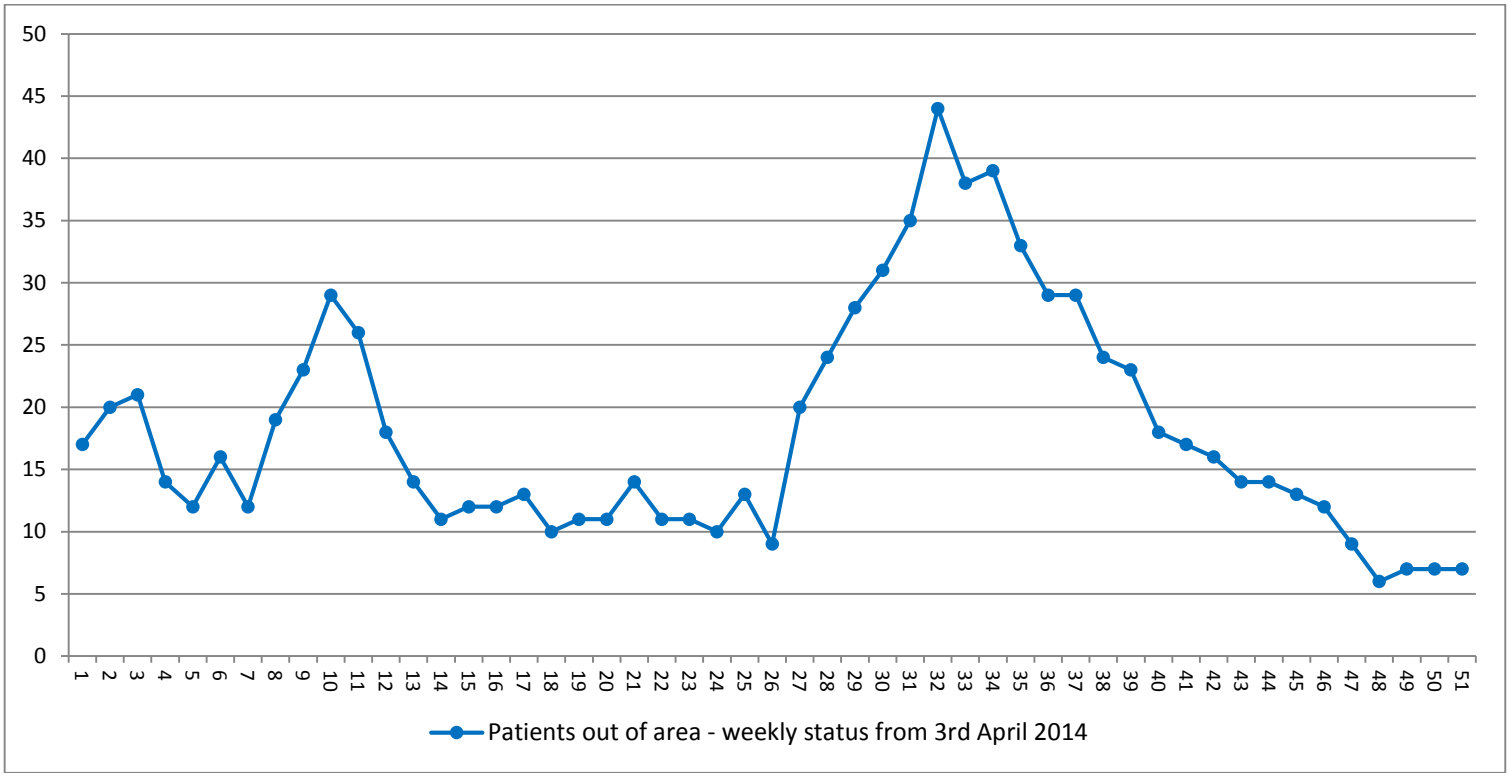
APPENDICES

Appendix 1

Out of Area Placements

1) Patients out of area, weekly status (from 3rd April 2014 to 19th March 2015)

Table 1



2) Those admitted out of area with parental responsibility for a child or children under age 18

Table 2

	CCG						
The number of acute mental health patients placed outside of NSFT where the patient has parental responsibility for a child or children under 18	NORTH NORFOLK	NORWICH	SOUTH NORFOLK	WEST NORFOLK	GY&W	Grand Total	%
NO	24	76	23	45	25	193	71%
YES	8	20	*	10	*	47	17%
Not on electronic record	*	13	*	*	*	30	11%
Grand Total	38	109	33	59	31	270	100%

*= a value between 1 & 6

3) Those admitted out of area that are identified as a carer for a disabled adult or elderly parent

Table 3

	CCG						
The number of acute mental health patients placed outside of NSFT where the patient has been identified as a carer for a disabled adult or an elderly parent	NORTH NORFOLK	NORWICH	SOUTH NORFOLK	WEST NORFOLK	GY&W	Grand Total	%
NO	32	96	27	55	30	240	89%
YES		*		*		*	1%
Not on electronic record	*	12	*	*	*	28	10%
Grand Total	38	109	33	59	31	270	100%

*= a value between 1 & 6

4) Locations to which the Out of Area patients have been sent:

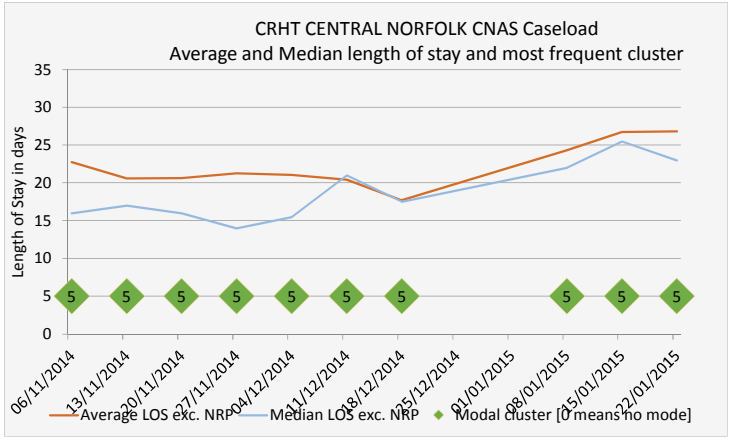
Table 4 * = a value between 1 and 6

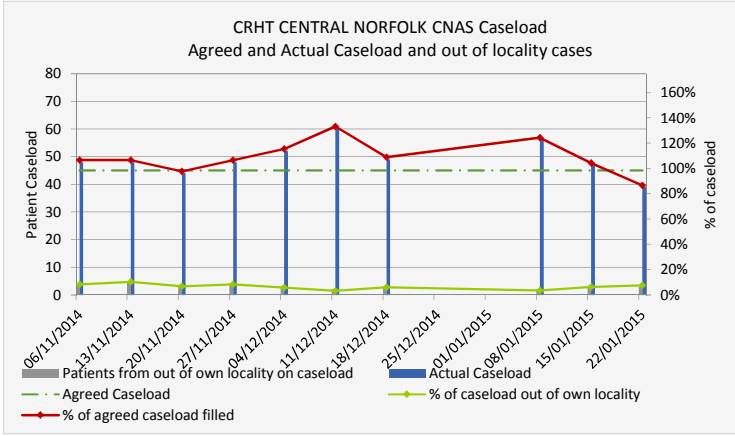
Out of Area Acute Mental Health Placements outside of N&SFT	CCG					
NAME OF PLACEMENT	NORTH NORFOLK	NORWICH	SOUTH NORFOLK	WEST NORFOLK	GY&W	Grand Total
BASILDON NHS			*		*	*
BASILDON NHS PICU		*	*			*
BASINGSTOKE NHS			*			*
CAMBIAN WILLOWS	*					*
CAMBRIDGE NHS					*	*
CHELMSFORD NHS	*	*				*
CHELMSFORD NHS PICU		*				*
CUMBRIA NHS				*		*
CYGNET BECKTON			*			*
CYGNET BIERLEY PICU		*				*
CYGNET BLACKHEATH			*			*
CYGNET BLACKHEATH PICU	*		*	*		*
CYGNET BRADFORD	*	*	*	*		*
CYGNET HARROGATE	*	*	*	*		9
CYGNET HARROW	*	*	*	*		*
CYGNET KEWSTOKE		*				*
CYGNET WESTON SUPERMARE PICU		*				*
GLOUCESTERSHIRE NHS	*					*
HEMEL HEMPSTEAD PRIORY				*		*
HUNTERCOMBE NORWICH		*				*
KENSINGTON AND CHELSEA NHS				*		*
KNEESWORTH HOUSE	*	12	*	8	8	36
NORTH EAST LONDON NHS			*			*
PRIORY ALTRNCHAM		*				*
PRIORY BRIGHTON		*		*		*
PRIORY BRISTOL		*		*		*
PRIORY CHEADLE	*	*	*	*	*	12
PRIORY CHEADLE PICU	*	*		*		*
PRIORY CHELMSFORD	7	18	*	*	*	39
PRIORY DARLINGTON		*		*		*
PRIORY HAYES GROVE	*	*				*
PRIORY HEMEL HEMPSTEAD	*				*	*
PRIORY NORTH LONDON	*	*	*	*	*	8
PRIORY NOTTINGHAM	*	11	*	8	*	26
PRIORY POTTERS BAR				*		*
PRIORY ROEHAMPTON	*	9	*	*	*	25
PRIORY SOUTHAMPTON	*					*
PRIORY ST NEOTTS	*	*			*	*
PRIORY TICEHURST	*	7	*	*	*	13
PRIORY WOKING		*		*	*	*
PRORY HAYES GROVE		*				*
ROYAL LONDON HOSPITAL NHS		*				*
SCARBOROUGH NHS	*					*
ST ANDREWS HEALTHCARE					*	*
THE DENE	*	11	*	7	*	22
THE SPINNEY				*		*
WAKEFIELD NHS		*				*
PRIORY CHELMSFORD & CHELMSFORD NHS PICU		*				*
CYGNET HARROGATE & PRIORY CHELMSFORD		*				*
Grand Total	38	109	33	59	31	270

i) Example of weekly Bed Status Report (for 22/01/15)

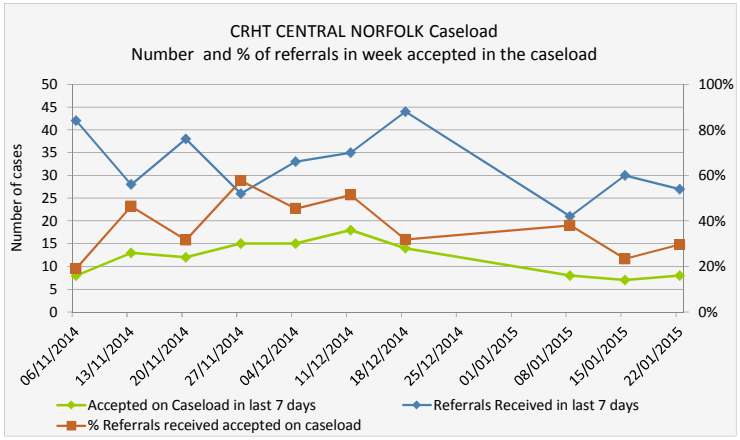
Crisis Home Resolution Team Central charts are shown as an example (full data and charts were supplied for all localities)
*= value between 1 and 6

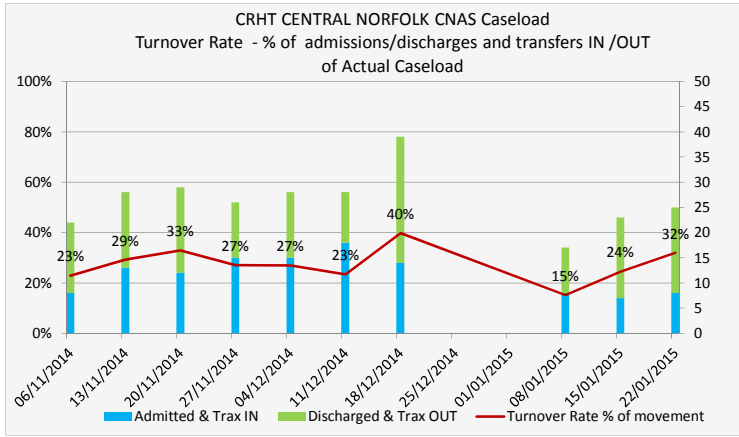
REPORT DATE	CASELOAD	Average LOS exc. NRP	Median LOS exc. NRP	% occupancy exc leave	% occupancy inc leave	Patients from out of own locality on caseload	% of caseload out of own locality	Modal cluster [0 means no mode]	Actual Caseload	Agreed Caseload	% of agreed caseload filled	Accepted on Caseload in last 7 days	Discharged in last 7 days	Referrals Received in last 7 days	% Referrals received accepted on caseload	Turnover Rate % of movement	% of Admissions that are transfers IN	% of Discharges that are transfers OUT			Admitted & Trax IN	Discharged & Trax OUT
06/11/2014	HTT CENTRAL NORFOLK	23	16.0			*	8%	5	48	45	107%	8	14	42	0.19047619	23%					8	14
13/11/2014	HTT CENTRAL NORFOLK	21	17.0			*	10%	5	48	45	107%	13	15	28	0.464285714	29%					13	15
20/11/2014	HTT CENTRAL NORFOLK	21	16.0			*	7%	5	44	45	98%	12	17	38	0.315789474	33%					12	17
27/11/2014	HTT CENTRAL NORFOLK	21	14.0			*	8%	5	48	45	107%	15	11	26	0.576923077	27%					15	11
04/12/2014	HTT CENTRAL NORFOLK	21	15.5			*	6%	5	52	45	116%	15	13	33	0.454545455	27%					15	13
11/12/2014	HTT CENTRAL NORFOLK	20	21.0			*	3%	5	60	45	133%	18	10	35	0.514285714	23%					18	10
18/12/2014	HTT CENTRAL NORFOLK	18	17.5			*	6%	5	49	45	109%	14	25	44	0.318181818	40%					14	25
08/01/2015	HTT CENTRAL NORFOLK	24	22.0			*	4%	5	56	45	124%	8	9	21	0	15%					8	9
15/01/2015	HTT CENTRAL NORFOLK	27	25.5			*	6%	5	47	45	104%	7	16	30	0	24%					7	16
22/01/2015	HTT CENTRAL NORFOLK	27	23.0			*	8%	5	39	45	87%	8	17	27	30%	32%					8	17





RETURN TO MENU





ii) Example of weekly NSFT Acute Dashboard (for 12/02/15)

ALL FIGURES RELATE TO ACTIVITY FOR WEEK ENDING **12/02/2015**

N&SFT CENTRAL WEST & GY&W ACUTE DASHBOARD

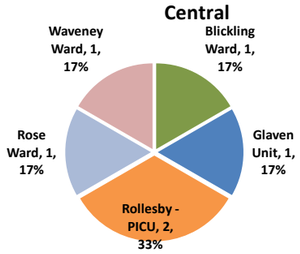
Norfolk and Suffolk NHS
NHS Foundation Trust

DTOC — BED DAYS DELAYED DUE TO TRANSFER OF CARE

	Central	West	GY&W	TRUST
DTOC5	5.8%	4.2%	5.4%	5.0%
DTOC1 Number of patients	6	1	4	23
4 week trend				

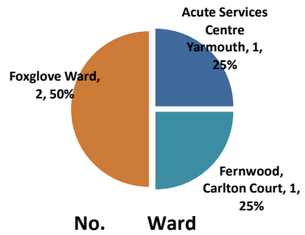
DTOC 6 — Location of patients experiencing a delayed transfer of care recorded on systems

Central



West

GY&W



DTOC 7

Internal delays	No.	Ward
Patient on PICU requiring an open ward	1	Rollesby
Patient on Acute Ward awaiting a CLL bed	1	Waveney Norwich
Patient on Acute Ward awaiting a continuing care bed	1	Blickling
Patient on Acute Ward awaiting CMHT support	1	Glaven

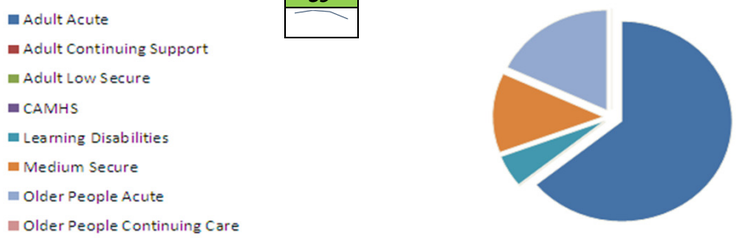
ADM — NORFOLK & GY&W ADMISSIONS TO TRUST

ADM 10-12

Number of referrals to Bed Management Team (Norfolk and GY&W)	39
Number of above admitted to Trust bed (Norfolk and GY&W)	26
Number admitted Out of Hours (Norfolk and GY&W)	13

ADM1 — Number of admissions, 4 week trend

TRUST
39

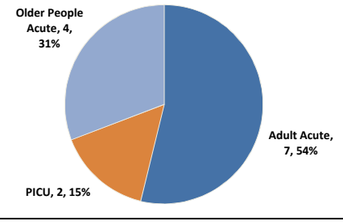


ADM1 — Number of admissions, 4 week trend

Central	West	GY&W
13	0	7

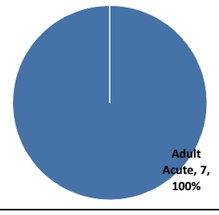
ADM 2-9

Central



West

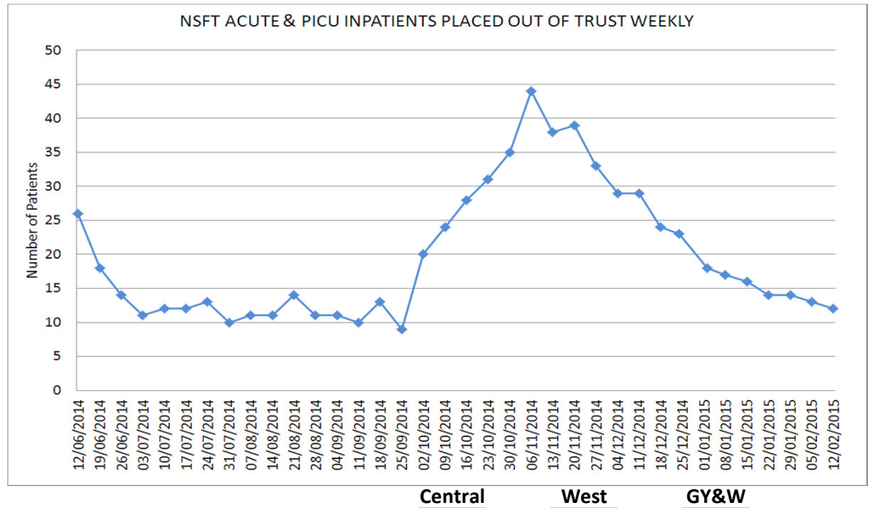
GY&W



OCCU — OCCUPIED BED DAYS

OCCU1	Central	West	GY&W	TRUST
% occupied inc. leave LD and secure	100%	126%	104%	96%
OCCU 2 - 6 Adult Acute	99%	126%	117%	101%
Adult Continuing	0%	0%	100%	95%
CAMHS	0%	0%	98%	98%
Older People Acute	104%	0%	0%	99%
Older Continuing Care	99%	0%	97%	98%
PICU	89%	0%	0%	72%

OOA — OUT OF AREA



OOA1 4 week trend	Central	West	GY&W
	11	0	1

PSYLIA — PSYCHIATRIC LIAISON NUMBER OF REFERRALS

PSYLIA1	Central	West	GY&W
Number of referrals, 4 week trend	38	11	6

CRHTDST — CRHT & DIST NUMBER OF REFERRALS

CRHTDST 1 - 2

CRHT Team	Central	West	GY	WAV
Received	34	12	20	0
Accepted	13	11	10	0
4 week trend accepted (accepted)				

CRHTDST 3 - 4

DIST Team	Central	West	GY&W
Received	27	8	7
Accepted	22	6	3
4 week trend accepted			

ALL FIGURES RELATE TO ACTIVITY FOR WEEK ENDING **12/02/2015**

N&SFT CENTRAL WEST & GY&W ACUTE DASHBOARD

Norfolk and Suffolk NHS
NHS Foundation Trust

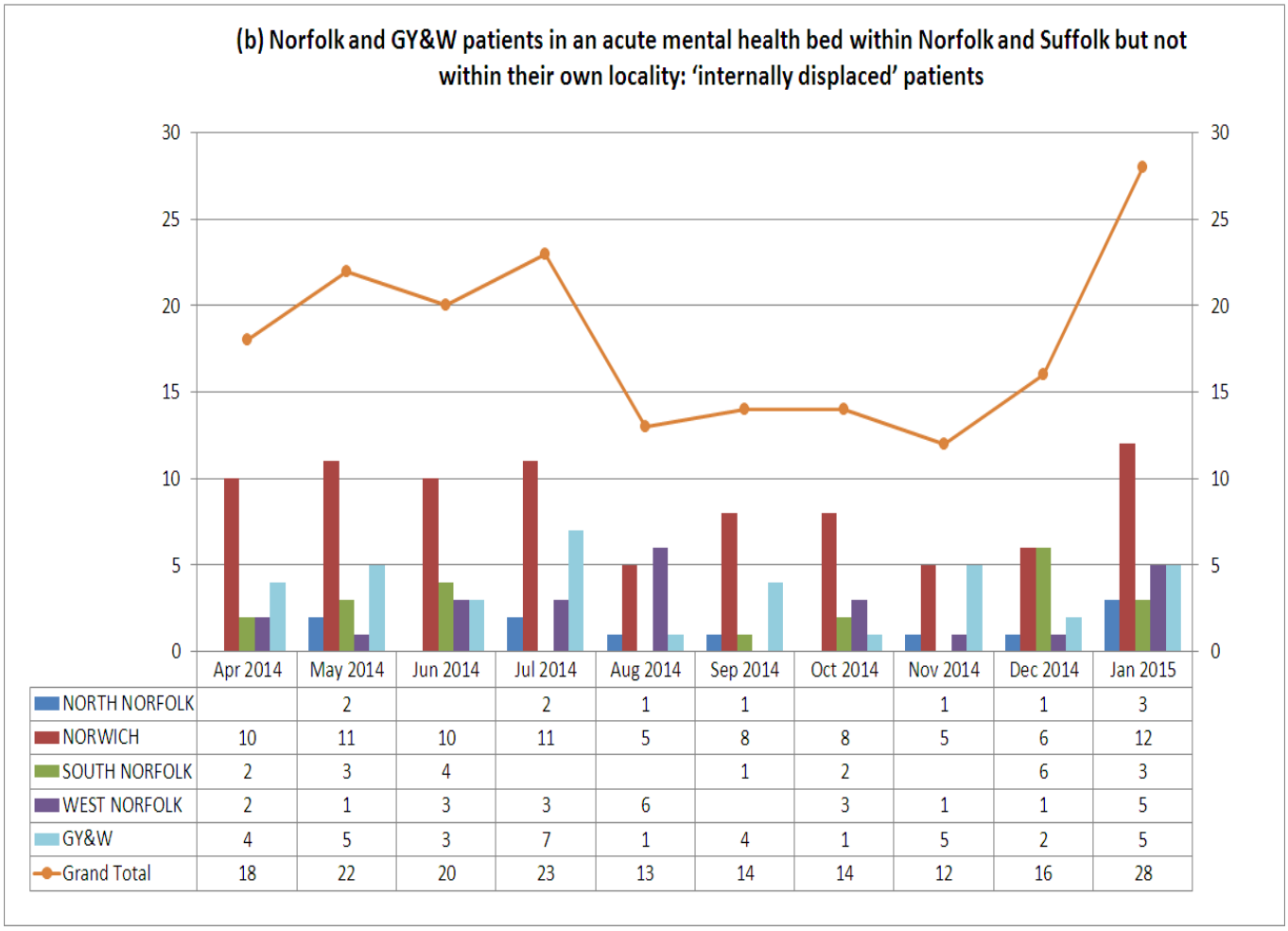
WARD CHARTS ILLUSTRATING DTOC, INTERNAL DELAYS AND VACANCIES REPORTED TO BED STATUS MEETING

Appendix 3

Out of CCG Area Placements within NSFT (April 2014 to January 2015)

1) Numbers and trends by Norfolk and Waveney CCGs

Table 1



	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015
NORTH NORFOLK		2		2	1	1		1	1	3
NORWICH	10	11	10	11	5	8	8	5	6	12
SOUTH NORFOLK	2	3	4			1	2		6	3
WEST NORFOLK	2	1	3	3	6		3	1	1	5
GY&W	4	5	3	7	1	4	1	5	2	5
Grand Total	18	22	20	23	13	14	14	12	16	28

2) Internally displaced patients with parental responsibility for a child or children under the age of 18

Table 2

	CCG						
The number of 'internally displaced' patients that have parental responsibility for a child or children under 18	NORTH NORFOLK	NORWICH	SOUTH NORFOLK	WEST NORFOLK	GY&W	Grand Total	%
NO	*	69	14	19	25	133	74%
YES	*	10	*	*	12	36	20%
Not on electronic record		7	*	*		11	6%
Grand Total	11	86	21	25	37	180	100%

* = a value between 1 and 6

3) Internally displaced patients that are an identified carer (e.g. for a disabled adult or elderly parent)

	CCG						
The number of 'internally displaced' patients that have been identified as a carer for a disabled adult or an elderly parent	NORTH NORFOLK	NORWICH	SOUTH NORFOLK	WEST NORFOLK	GY&W	Grand Total	%
NO	11	80	19	23	37	170	94%
YES		*				*	* %
N/A		*	*	*		*	* %
Grand Total	11	86	21	25	37	180	100%

* = a value between 1 and 8

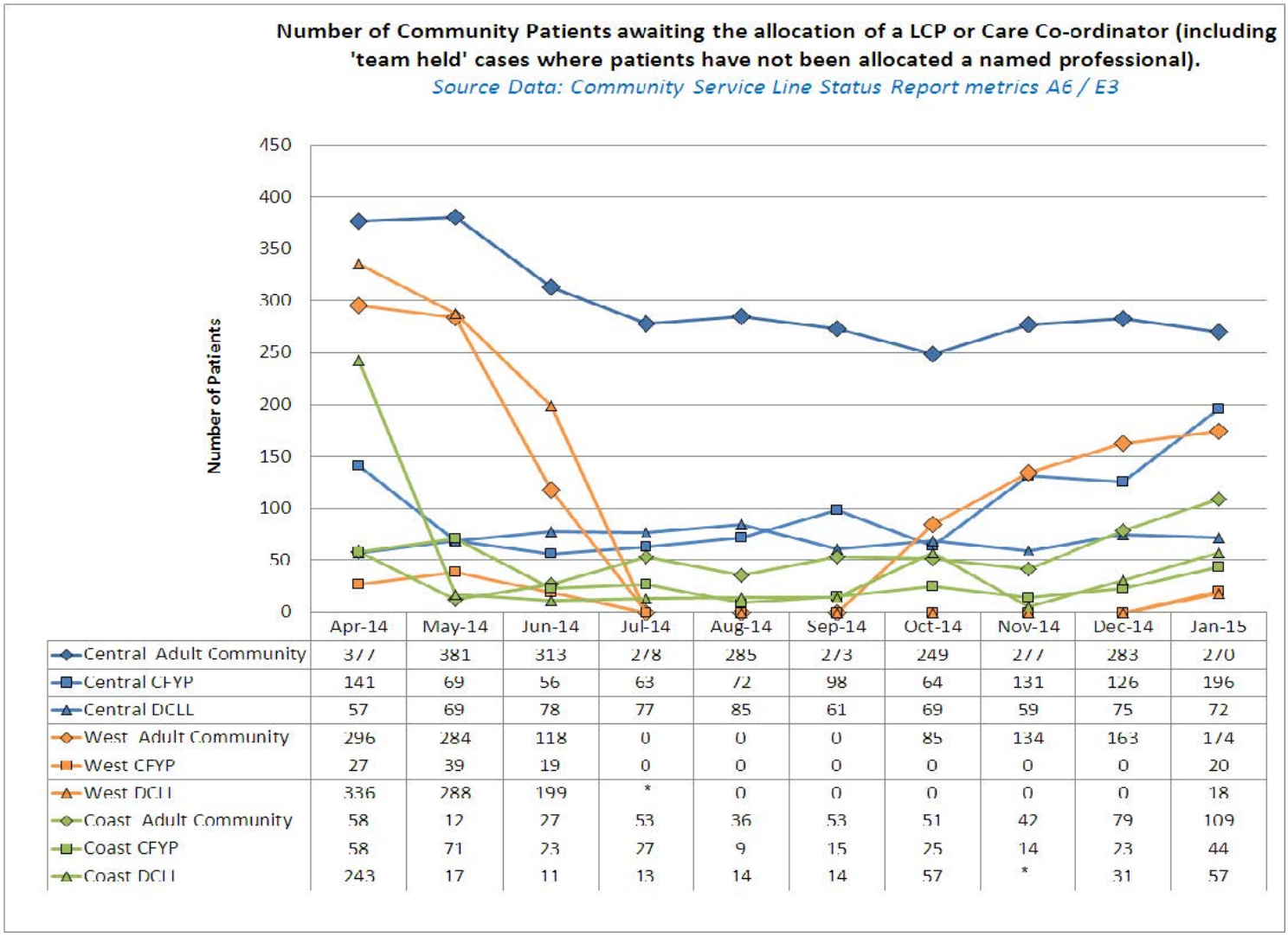
Appendix 4

Patients awaiting allocation to a named professional (April 2014 to January 2015)

Patients referred for community services between April 13 and January 14 awaiting allocation of a lead care professional or care coordinator including 'team held' cases not allocated to a named professional.

1) Unallocated (waiting list) patients by Locality and Service line

Table 1

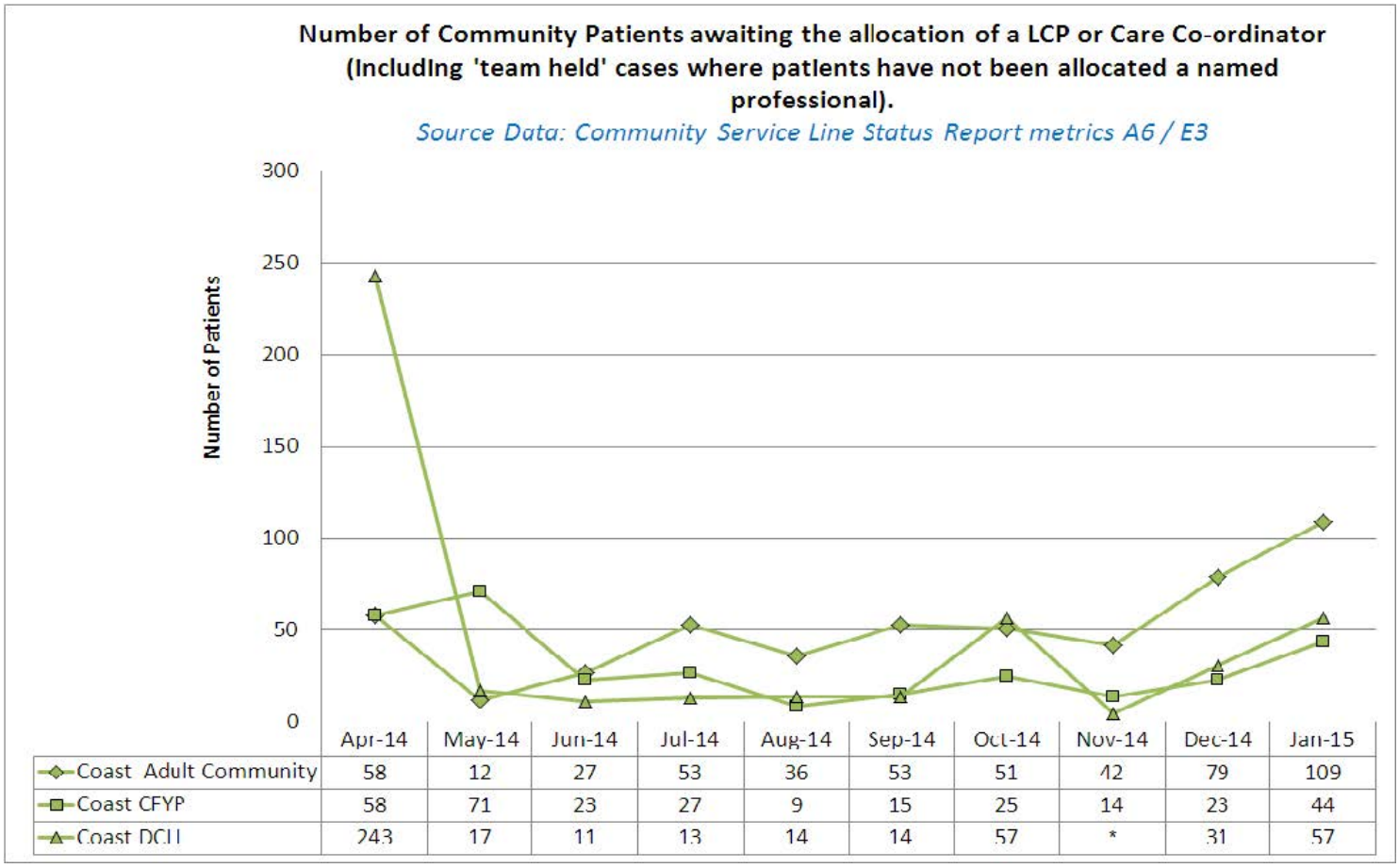


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Central Adult Community	377	381	313	278	285	273	249	277	283	270
Central CFYP	141	69	56	63	72	98	64	131	126	196
Central DCLL	57	69	78	77	85	61	69	59	75	72
West Adult Community	296	284	118	0	0	0	85	134	163	174
West CFYP	27	39	19	0	0	0	0	0	0	20
West DCLL	336	288	199	*	0	0	0	0	0	18
Coast Adult Community	58	12	27	53	36	53	51	42	79	109
Coast CFYP	58	71	23	27	9	15	25	14	23	44
Coast DCLL	243	17	11	13	14	14	57	*	31	57

* = a value between 1 and 6

2) Unallocated (waiting list) patients in Great Yarmouth & Waveney

Table 2

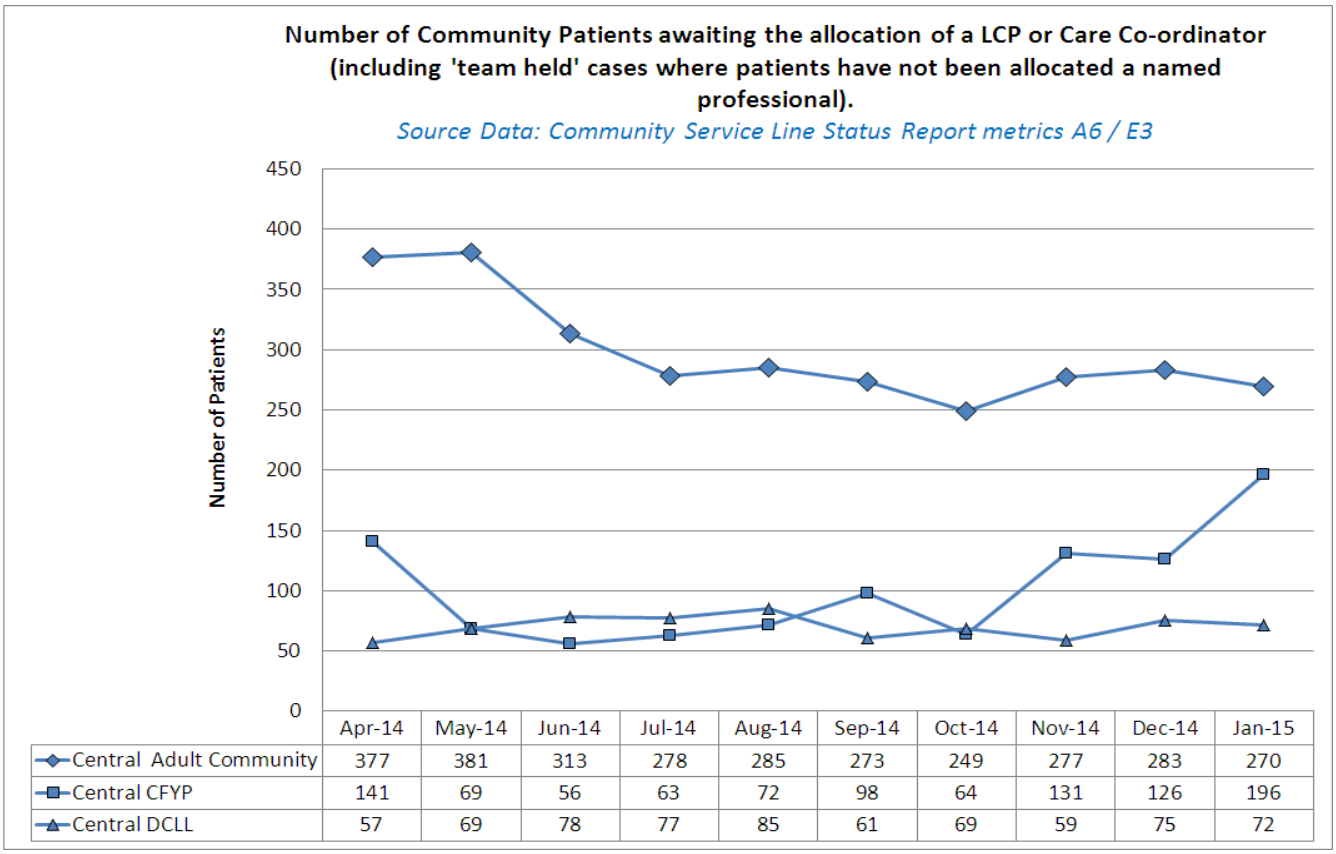


	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Coast Adult Community	58	12	27	53	36	53	51	42	79	109
Coast CFYP	58	71	23	27	9	15	25	14	23	44
Coast DCII	243	17	11	13	14	14	57	*	31	57

* = a value between 1 and 6

3) Unallocated (waiting list) patients in the Central Locality by Service Line

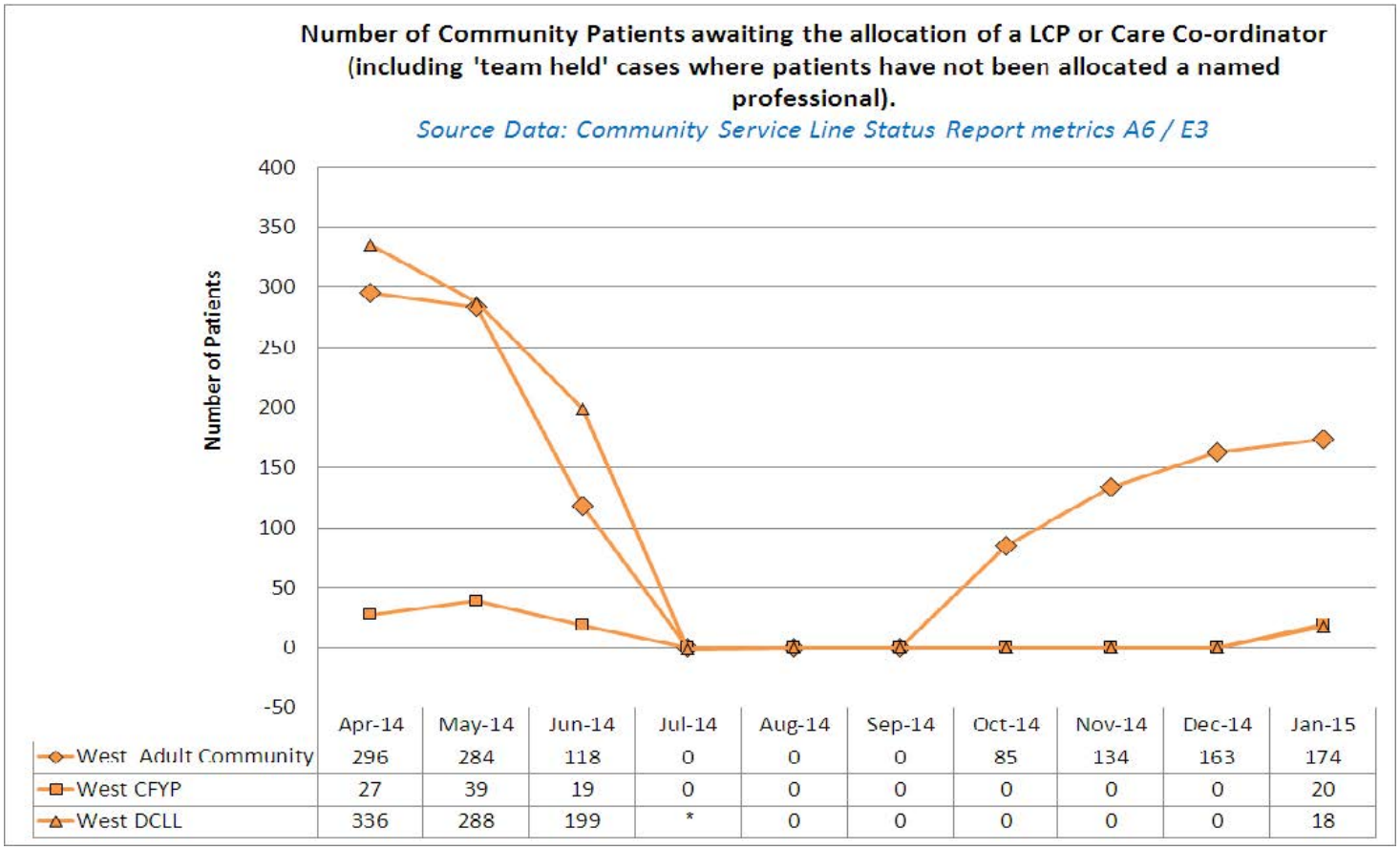
Table 3



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Central Adult Community	377	381	313	278	285	273	249	277	283	270
Central CFYP	141	69	56	63	72	98	64	131	126	196
Central DCLL	57	69	78	77	85	61	69	59	75	72

3) Unallocated (waiting list) patients in the West Locality by Service Line

Table 4



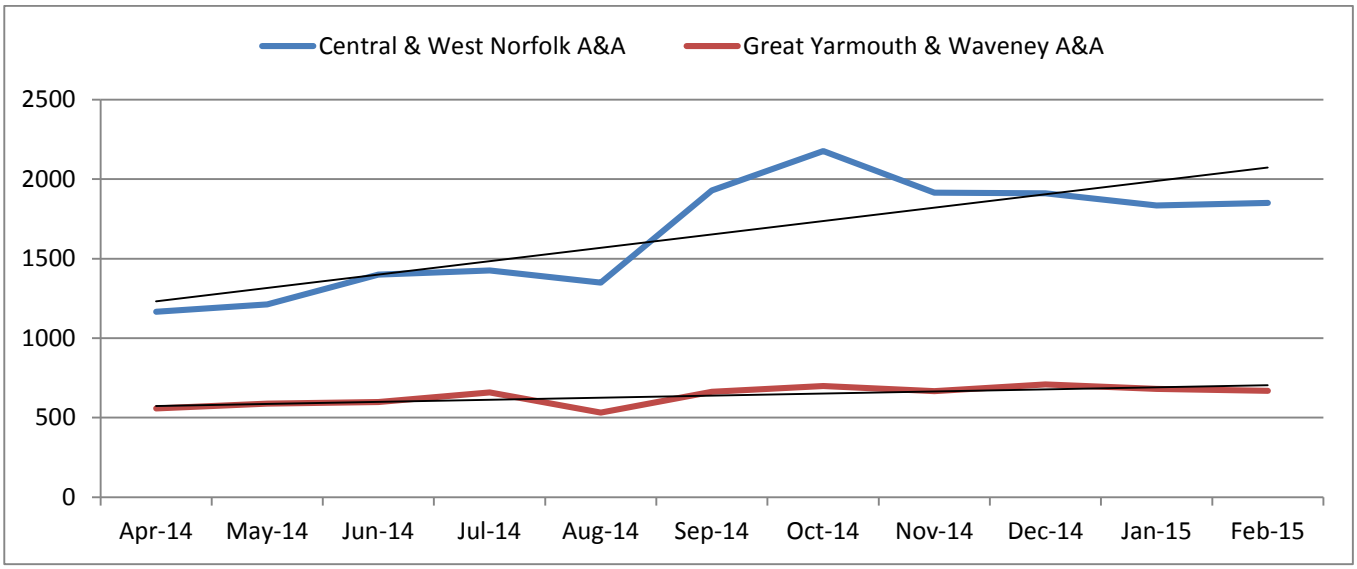
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
West Adult Community	296	284	118	0	0	0	85	134	163	174
West CFYP	27	39	19	0	0	0	0	0	0	20
West DCLL	336	288	199	*	0	0	0	0	0	18

* = a value between 1 and 6

Appendix 5

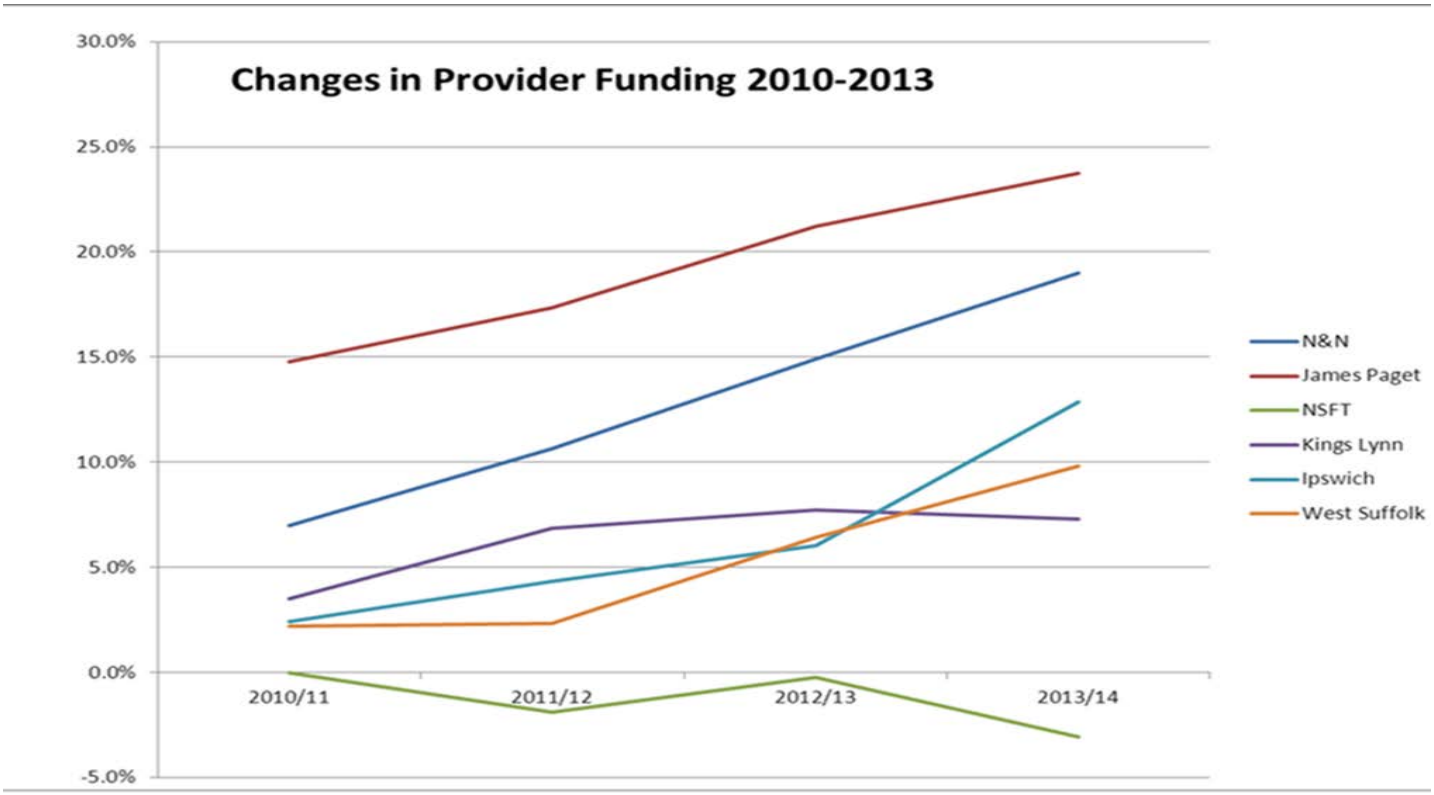
Demand / Funding Disparity

i) Referrals to NSFT Access & Assessment Teams in Norfolk and Waveney



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
C&W A&A	1166	1212	1400	1426	1350	1929	2177	1915	1912	1834	1851
GYW A&A	558	589	599	660	533	664	700	667	710	682	670

i) NSFT funding by comparison with Acute Trusts in Norfolk & Suffolk

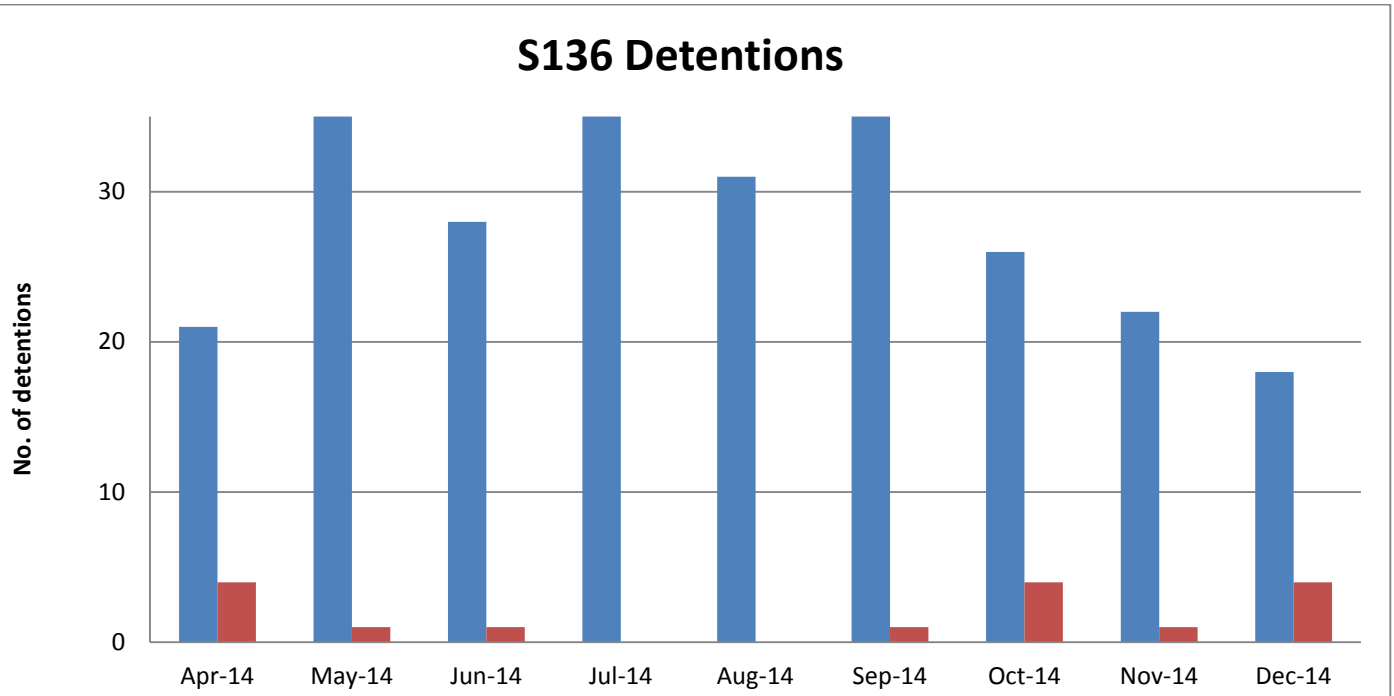


Appendix 6

Section 136 detentions (April 2014 to January 2015)

Section 136 detentions in 136 suites and A&E

Table 1



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
S136 suite	21	36	28	35	31	40	26	22	18
PIC	*	*	*	0	0	*	*	*	*

* = a value between 1 and 6

2011/15 Q3, Section 136 suite detention times where known

Table 2

Detention time	No of individuals
0 – 3 hours	7
3 – 6 hours	19
6 – 9 hours	4
9+ hours	9
Not recorded or unknown	27

Appendix 7

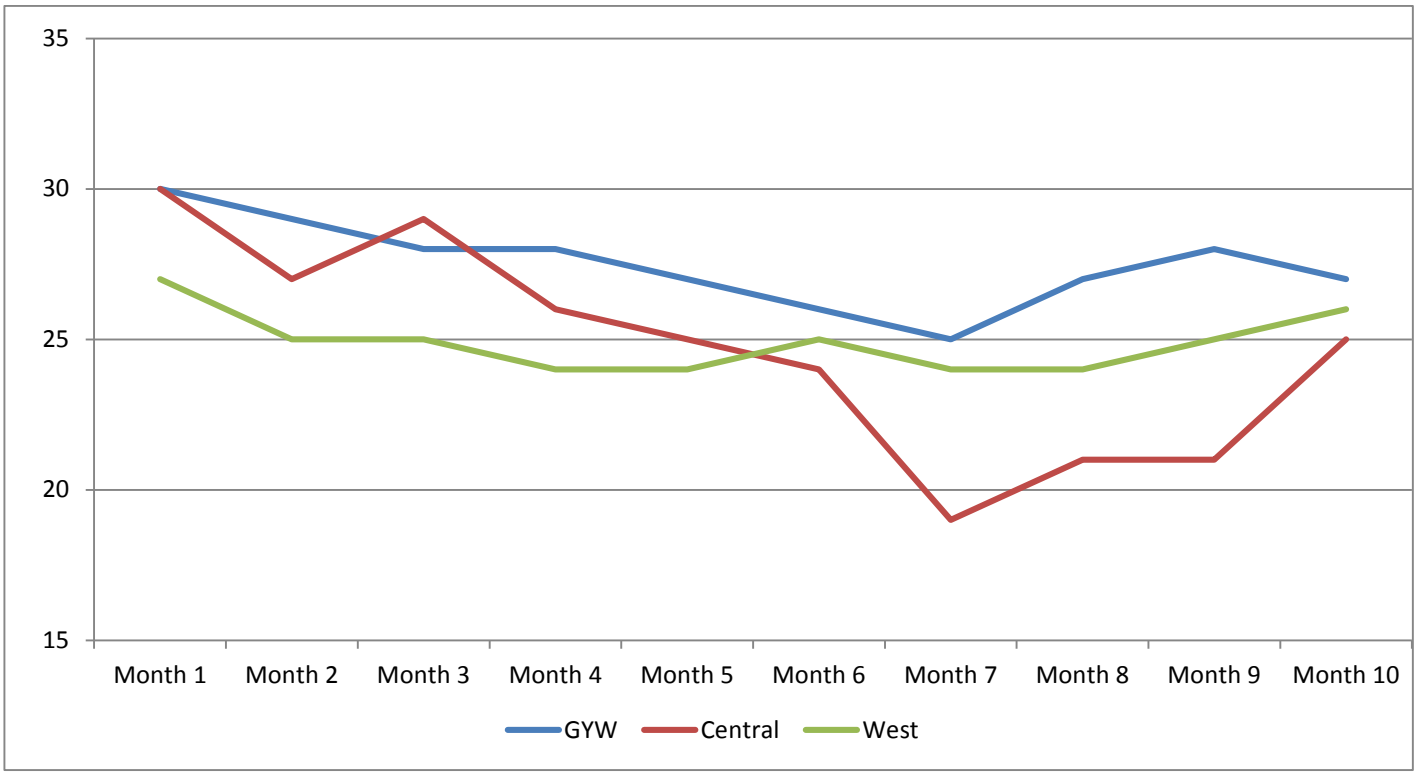
Community Caseloads by non-medical Registered Mental Health Practitioner

Average Caseloads per WTE MHP (April 14 to January 15):

1) Children, Families and Young People Service Line

Table 1

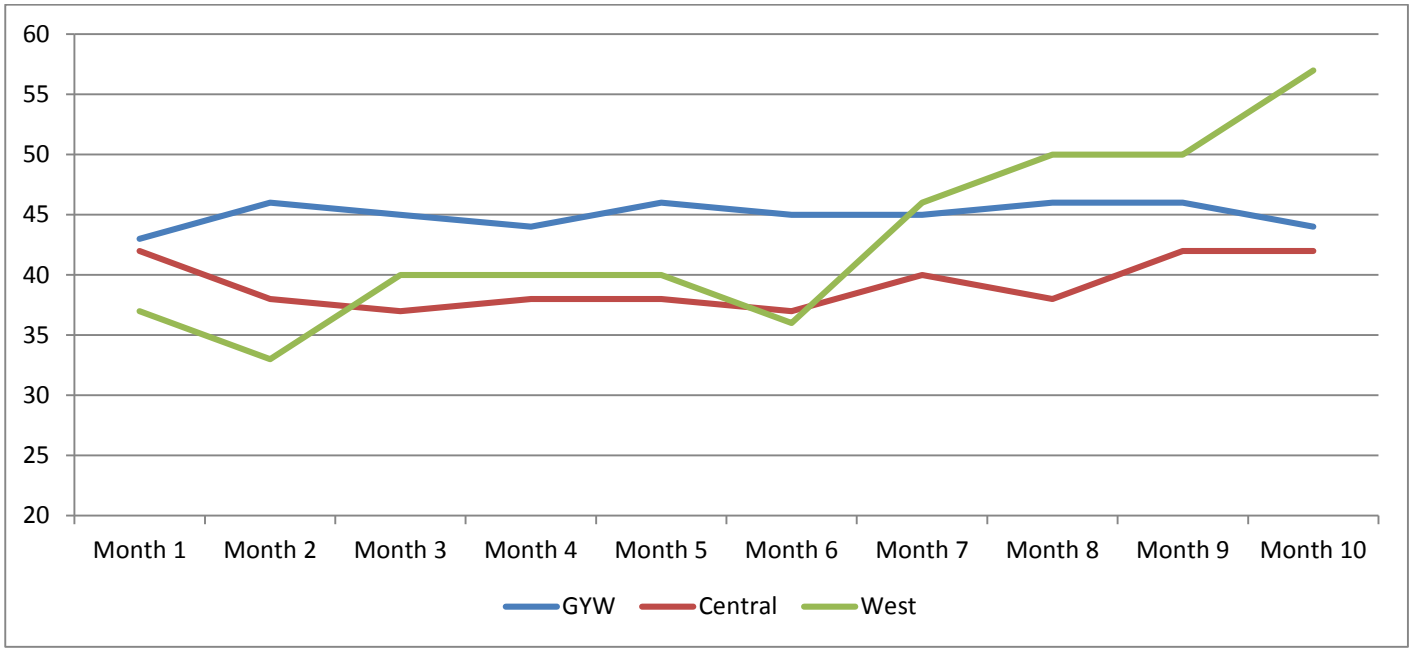
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
GYW	30	29	28	28	27	26	25	27	28	27
Central	30	27	29	26	25	24	19	21	21	25
West	27	25	25	24	24	25	24	24	25	26



2) Adult Community Service Line

Table 2

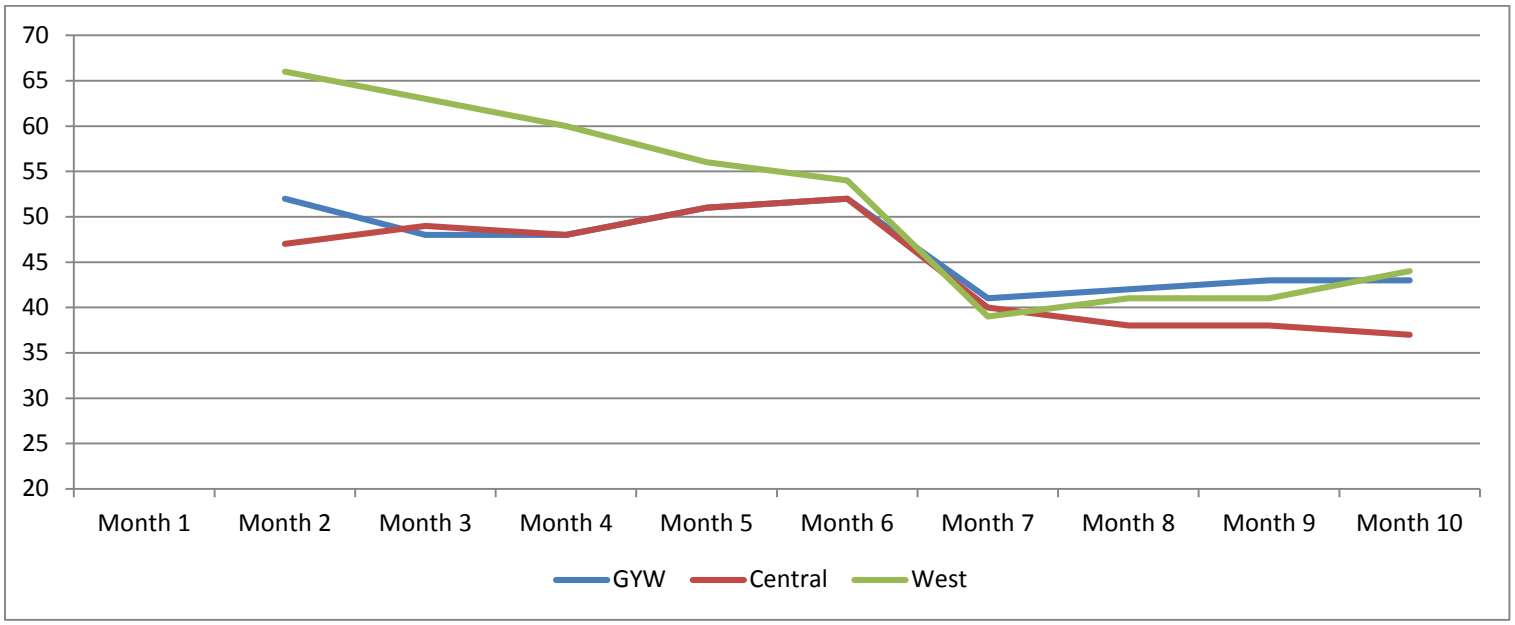
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
GYW	43	46	45	44	46	45	45	46	46	44
Central	42	38	37	38	38	37	40	38	42	42
West	37	33	40	40	40	36	46	50	50	57



3) Dementia and Complexity in Later Life Service Line

Table 3

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
GYW	-	52	48	48	51	52	41	42	43	43
Central	-	47	49	48	51	52	40	38	38	37
West	-	66	63	60	56	54	39	41	41	44



Appendix 8 - More Quality & Safety Performance indicator monitoring documents (see also Appendix 1a)

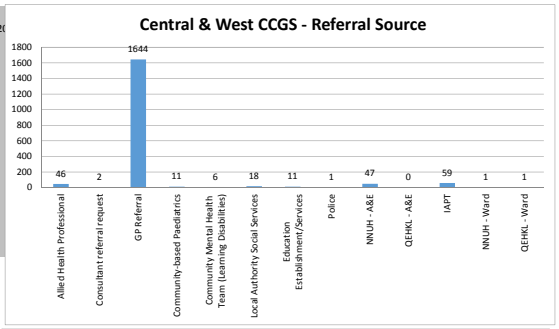
(i) Central & West Norfolk Access and Activity Report (for Feb 2015)

NSFT Norfolk Access & Assessment - Central & West CCGS

Norfolk and Suffolk NHS
NHS Foundation Trust

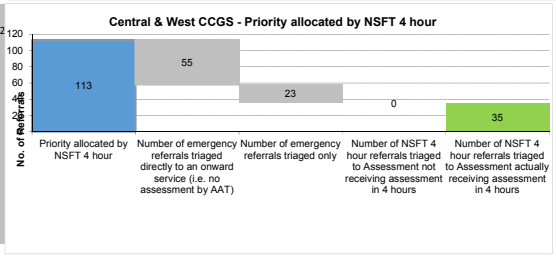
Referral Sources for the period:

01/02/2015	to	28/02/2015
Allied Health Professional	46	
Consultant referral request	2	
GP Referral	1644	
Community-based Paediatrics	11	
Community Mental Health Team (Learning Disabilities)	6	
Local Authority Social Services	18	
Education Establishment/Services	11	
Police	1	
NNUH - A&E	47	
QEHKL - A&E	0	
IAPT	59	
NNUH - Ward	1	
QEHKL - Ward	1	
Total number of referrals received	**1847**	



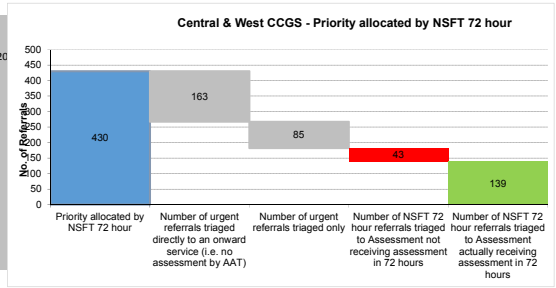
Emergency referrals for the period:

01/02/2015	to	28/02/2015
Priority allocated by NSFT 4 hour	113	
Number of emergency referrals triaged directly to an onward service (i.e. no assessment by AAT)	55	
Number of emergency referrals triaged only	23	
Number of NSFT 4 hour referrals triaged to Assessment not receiving assessment in 4 hours	0	
Number of NSFT 4 hour referrals triaged to Assessment actually receiving assessment in 4 hours	35	
% of NSFT 4 hour referrals triaged to Assessment actually receiving assessment in 4 hours	**100.0%**	
Target	95.0%	



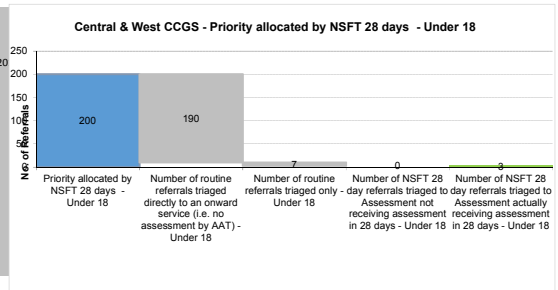
Urgent referrals for the period:

01/02/2015	to	28/02/2015
Priority allocated by NSFT 72 hour	430	
Number of urgent referrals triaged directly to an onward service (i.e. no assessment by AAT)	163	
Number of urgent referrals triaged only	85	
Number of NSFT 72 hour referrals triaged to Assessment not receiving assessment in 72 hours	43	
Number of NSFT 72 hour referrals triaged to Assessment actually receiving assessment in 72 hours	139	
% of NSFT 72 hour referrals triaged to Assessment receiving assessment in 72 hours	**76.4%**	
Target	95.0%	



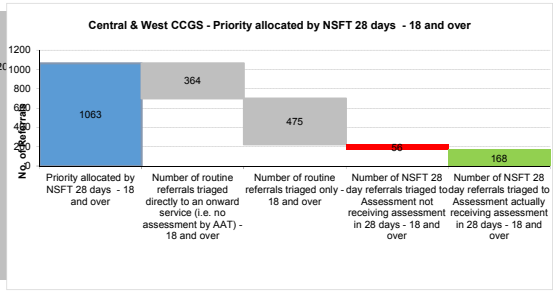
Routine Under 18 referrals for the period:

01/01/2015	to	31/01/2015
Priority allocated by NSFT 28 days - Under 18	200	
Number of routine referrals triaged directly to an onward service (i.e. no assessment by AAT) - Under 18	190	
Number of routine referrals triaged only - Under 18	7	
Number of NSFT 28 day referrals triaged to Assessment not receiving assessment in 28 days - Under 18	0	
Number of NSFT 28 day referrals triaged to Assessment actually receiving assessment in 28 days - Under 18	3	
% of NSFT 28 day referrals triaged to Assessment actually receiving assessment in 28 days	**100.0%**	
Target	95.0%	
Number of routine referrals (Under 18) in current reporting period (01/02/2015 to 28/02/2015)	219	



Routine 18 and over referrals for the period:

01/01/2015	to	31/01/2015
Priority allocated by NSFT 28 days - 18 and over	1063	
Number of routine referrals triaged directly to an onward service (i.e. no assessment by AAT) - 18 and over	364	
Number of routine referrals triaged only - 18 and over	475	
Number of NSFT 28 day referrals triaged to Assessment not receiving assessment in 28 days - 18 and over	56	
Number of NSFT 28 day referrals triaged to Assessment actually receiving assessment in 28 days - 18 and over	168	
% of NSFT 28 day referrals triaged to Assessment actually receiving assessment in 28 days	**75.0%**	
Target	95.0%	
Number of routine referrals (18 and over) in current reporting period (01/02/2015 to 28/02/2015)	1085	



Referral Outomes for the period:

01/01/2015	to	31/01/2015
Number triaged to IAPT Service	368	
Signposted	254	
Advice only	0	
Did not attend	39	
Social care	0	
Number triaged to Norfolk Recovery Partnership	0	
Assessed and discharged - no onward service	398	

Appendix 8 (ii) Community Service Line Status Report Status Report (for February 2015)

Full data for all community service lines provided. Adult community service dashboards for central, coast and west are shown below as an example.

RETURN TO MENU

COMMUNITY SERVICE LINE STATUS REPORT 2014-15

Service Line: Adult Community | **Locality: Central** | **Feb-2015**

A: Caseload Status			B: Workforce Status (WTE)			C: Caseload Turnover Status			D: Caseloads per Practitioner			E: Waiting times		
A1	Caseload RAG rating	138%	B1	Workforce RAG rating	89%	C1	Referral/Discharge RAG rating	-65	D1	Caseload per registered clinical WTE RAG rating	*33*	E1	Total Number Waiting	258
A2	Target Caseload	1834	B2	Planned Medical registered Est.	8.8	C2	Number of new referrals to service line	99	D2	Medical Registered staff included in calculation	0	E2	Average waiting times RAG rating	107
A3	Actual Caseload	2533	B3	Planned Non-Medical registered Est.	76.2	C3	Number of discharges from service line	164				E3	Number of referrals to Service Line awaiting caseload allocation	267
A4	CPA/Care Coordination status recorded	691	B4	Planned unregistered Est.	36.5									
A5	Non CPA/Lead Care Professional status recorded	1575	B5	Medical Registered staff vacancies/absences	0.0									
A6	Referral without a CPA status recorded	267	B6	Non-Medical Registered staff vacancies/absences	-7.0									
A7	Total	2533	B7	Unregistered staff vacancies/absences	-6.4									
			B8	Registered staff in post	77.9									

COMMENTARY

(to start a new paragraph in the same cell press Alt and ↵, to cut and paste text - copy and paste into into the *fx* bar)

Non Medical registered staff in post includes 11.8 wte Psychology and Psycological Therapy staff who do not hold caseloads as high as Band's 5 and 6 staff. Medical Staff do not hold caseload therefore the total number of staff who hold a full caseload is only 44.66wte

A RAG		B RAG		C RAG		D RAG		E RAG	
Within 15% of agreed total	%	Less than 8% underestablished	%	120 or more discharges than referrals		Up to 35 per WTE		Up to 28 days average wait	
Within 30%	%	Between 8% and 15% underestablished	%	0 to 119 more discharges than referrals		36 to 45 per WTE		29 to 70 days	
Over 30%	%	Greater than 15% underestablished	%	More referrals than discharges		46 or more per WTE		71 days or more	

NOTES		NOTES		NOTES		NOTES		NOTES	
A1	See notes above	B1	See notes above	C1	Number of new referrals to Service Line minus the number of discharges from the Service line	D1	([A3] Total Caseload) / [B8] Registered staff in post)	E1	Total number reeferred to Service line waiting to be treated in Service line
A2	Target Caseload	B2	Used to calculate [D1] if inclusion of Medical staff is appropriate for the Service	C2	Number of new referrals to service line	D2	Denotes whether Medical Establishment have been included in the calculation of caseload [D1] as appropriate to Service Line	E2	Average waiting time in days from referral to onward Service line to treatment within Service line
A3	The number of unique patients with an open referral on the system for this Service line	B3	Planned Non-Medical registered Establishment WTE	C3	Number of discharges from service line			E3	Completed by the Service Line using most appropriate methodology commentary on this figure will be required
A4	CPA or Care Coordination status recorded	B4	Planned unregistered Establishment WTE						
A5	Non-CPA or Lead Care Professional status recorded	B5	Used to calculate [D1] if inclusion of Medical staff is appropriate for the Service						
A6	Referral without a CPA status recorded is a calculated field = (A3-(A4+A5))	B6	Non-Medical Registered staff vacancies and or absences WTE						
		B7	Unregistered staff vacancies and or absences WTE						
		B8	Calculated field dependent on inclusion or exclusion of Medical Establishment						

RETURN TO MENU

COMMUNITY SERVICE LINE STATUS REPORT 2014-15

Service Line: Adult | **Locality: Coast** | Mon | **Feb-2015**

A: Caseload Status			B: Workforce Status (WTE)			C: Caseload Turnover Status			D: Caseloads per Practitioner			E: Waiting times		
A1	Caseload RAG rating	137%	B1	Workforce RAG rating	77%	C1	Referral/Discharge RAG rating	-2	D1	Caseload per registered clinical WTE RAG rating	44	E1	Total Number Waiting	14
A2	Target Caseload	1106	B2	Planned Medical registered Est.	0.0	C2	Number of new referrals to service line	57	D2	Medical Registered staff included in calculation	NO	E2	Average waiting times RAG rating	43
A3	Actual Caseload	1516	B3	Planned Non-Medical registered Est.	42.6	C3	Number of discharges from service line	59				E3	Number of referrals to Service Line awaiting caseload allocation	98
A4	CPA/Care Coordination status recorded	375	B4	Planned unregistered Est.	21.5									
A5	Non CPA/Lead Care Professional status recorded	1043	B5	Medical Registered staff vacancies/absences	0.0									
A6	Referral without a CPA status recorded	98	B6	Non-Medical Registered staff vacancies/absences	-7.8									
A7	Total	1516	B7	Unregistered staff vacancies/absences	-7.2									
			B8	Registered staff in post	34.9									

COMMENTARY

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Developmental Disorder referrals have been moved to new team - marked reduction in waiting times.

RETURN TO MENU

COMMUNITY SERVICE LINE STATUS REPORT 2014-15

Service Line: Adult Community | **Locality: West** | **Feb-2015**

A: Caseload Status			B: Workforce Status (WTE)			C: Caseload Turnover Status			D: Caseloads per Practitioner			E: Waiting times		
A1	Caseload RAG rating	141%	B1	Workforce RAG rating	*91%*	C1	Referral/Discharge RAG rating	28	D1	Caseload per registered clinical WTE RAG rating	55	E1	Total Number Waiting	20
A2	Target Caseload	525	B2	Planned Medical registered Est.	0.0	C2	Number of new referrals to service line	49	D2	Medical Registered staff included in calculation	NO	E2	Average waiting times RAG rating	91
A3	Actual Caseload	738	B3	Planned Non-Medical registered Est.	15.4	C3	Number of discharges from service line	21				E3	Number of referrals to Service Line awaiting caseload allocation	189
A4	CPA/Care Coordination status recorded	102	B4	Planned unregistered Est.	7.0									
A5	Non CPA/Lead Care Professional status recorded	636	B5	Medical Registered staff vacancies/absences	0.0									
A6	Referral without a CPA status recorded	0	B6	Non-Medical Registered staff vacancies/absences	-2.0									
A7	Total	738	B7	Unregistered staff vacancies/absences	0.0									
			B8	Registered staff in post	13.4									

COMMENTARY

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NSFT Serious Incident / Never Event Report – February 2015

1. Executive Summery

The group are asked to note the following items for discussion;

- **Item 4 overdue Si's- Page 4**
- **Item 5 SI's requiring further assurance/ information –Page 4**
- **Item 7 –Never Events –Page 4**

2. Serious Incident (SIs) reported by the NSFT:

Year	Number of SIs reported
2012/13	96
2013/14	82
01/04/14 – 28/02/15	74

The table below shows SIs reported between April 2014 and February 2015 broken down into categories:

Category	April	May	June	July	August	September	October	November	December	January	February
Admission of Under 18 to Adult Mental Health Ward	1	1	0	1	0	0	0	0	0	0	0
Allegation against Professional	0	2	1	1	1	0	0	0	1	0	3
Assault	1	0	0	0	0	0	0	0	0	1	0
Fall	0	2	1	2	0	0	0	0	0	0	0
Information Governance	0	0	1	0	0	0	0	0	0	0	0
Confidential Information Leak	0	0	0	0	1	0	0	0	0	0	0
Pressure Ulcer Grade 3	0	1	0	0	0	0	0	0	0	1	0
Safeguarding - Vulnerable Adult	0	0	0	1	0	0	0	0	0	0	0
Serious Incident by Inpatient (in receipt)	0	0	0	0	1	0	0	0	0	1	1
Serious Incident by Outpatient (in receipt)	2	0	0	0	1	0	0	0	0	0	0
Triage & Assessment of referral regarding youth pathway	0	0	1	0	0	0	0	0	0	0	0
Unexpected death (including Community patient in receipt)	5	1	8	2	2	5	2	3	2	4	1
Unexpected death of Community patient not in receipt	0	0	0	0	2	0	0	0	4	0	1
Access to Services	0	0	0	0	0	0	1	0	0	0	0
Total	9	7	12	7	8	5	3	3	7	7	6

3. SIs reported in February 2015

Six SIs were reported in February 2015 (three Allegation against HC professional, two Unexpected Deaths of Community patients, one Serious Incident by Inpatient).

4. Overdue SIs

There are currently two overdue RCA reports.
2014/35373 – RCA due 05/01/15
2014/39376 – RCA due 09/02/15
Both of the RCA reports have been requested by the SI facilitator

5. Open SI's requiring further assurance/ information

2014/28611 – Telephone call received from Social Worker to Trust DIST staff to advise that a community service user was found dead in their home by Care Agency staff who were visiting him on the morning of 29th August. The Coroner's Office today confirmed that the post mortem result proved the service user to have died from a Pulmonary Thrombo-embolism -update required against actions relating to DR in the case.

2013/28573 –Rollesby ward- PICU-Patient (Section 3 MHA) was being nursed in de-escalation area due to risk behaviours (for last 8 days). Due to increase in risk behaviour patient was secluded. A drink and sandwich had been placed in the seclusion room. The staff member, observing the area, heard the patient to be choking and called for assistance. CPR commenced and ambulance called. Patient taken to local acute general hospital where he is in a critical condition. grade 2 SI, update required on the action plan. CCG still awaiting the addendum.

2014/37282 –Patient referred to Central Locality Crisis Resolution and Home Treatment Team on 14 November. Staff contacted family on Friday (14th) and Saturday (15th) but were unable to assess the patient. On Sunday 16th November staff spoke with husband who reported the patient had gone missing between 02:00 and 05:00. Later informed the patient's body had been found in a fishing lake near the house. NSFT has been given a deadline of 09.02.15 for RCA to be updated

6. Voids

No SIs were voided during February 2015 for NSFT

7. Never Events

There have been no Never Events reported in February 2015 for the Norfolk Lead Commissioner (SNCCG). There has been one Never Event for Gt Yarmouth and Waveney CCG (GYWCCG), which is noted due to reputational risk for NSFT.

2015/7458 – Homicide by Outpatient (not in receipt) - Trust informed that a former patient had been arrested by the police on suspicion of causing the death of another person. This has been reported in the local media.

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Quality Governance Committee.
Meeting Date:	24th March 2015
Title of Report:	Risk Management
Action Sought:	For information

Purpose of the Report	Information and Comment

Implications:	Comply with Health & Safety Legislation, CQC

Author:	Neil Paull (Risk & Security Manager)
Director:	Jane Sayer – Director of Nursing, Quality and Patient Safety

Executive Summary:

Risk Management review for compliance with National Report Learning System (NRLS), monitoring of risk and review of current trends

- This paper provides the Committee with an outline of the current incident reporting trends and risks within the Trust.
- The Committee is invited to identify any areas of concern and/or good practice for further reporting and gain assurance on any areas of concern.

1 INCIDENT REPORTING

Incident reporting data has increased significantly in the reporting (February) on the same period as last year from a total of 941 to 1343 recorded events;

NORFOLK INCIDENTS – top 5	Feb 2014	Feb 2015
Physical Assaults	67	153
Slip, Trip, Fall - Service User	57	61
Concern - Service Deficit / Staffing	84	53
Non-Physical Assaults	44	54
Deliberate self harm	22	32

SUFFOLK INCIDENTS - top 5	Feb 2014	Feb 2015
Physical Assaults	32	97
Non-Physical Assaults	37	84
Concern - Service Deficit / Staffing	60	63
Deliberate self harm	16	63
Slip, Trip, Fall - Service User	29	26

FORENSIC SERVICE INCIDENTS	Feb 2014	Feb 2015
Non-Physical Assaults	54	41
Concern - Service Deficit / Staffing	28	16
Physical Assaults	36	23
Deliberate self harm	15	34
Security/Environmental	7	13

The incident reporting was also up on the previous month (January 2015) from 1198 events.
The top 5 incidents for Norfolk and Suffolk are similar, with Physical and Non-Physical Assaults remaining high, Concern – Service Deficit/Staffing remaining in the top 3 (although reporting continues to reduced in Norfolk and Forensic Services), with Slips, Trips, Falls and Deliberate self harm completing the top 5 and Security/Environment being reported within Secure Services, taking the place of Inappropriate Behaviour.

The Secure Services events have been raised with the Service manager, as there is a trend of unsecured rooms and equipment. At this stage it does they do not appear to be linked.

Recording of Physical and Non physical assaults have increased in Norfolk and Suffolk, although there has also been a strong focus on recording restraint events and this may have raised awareness in this high reporting area, which will continue to be monitored and shared with the Service leads.

	Secure Serv.	**Feb 2014**	**Secure Serv.**	**Feb 2015**
Norfolk	**163**	**466**	89	**698**
Death - Not patient safety incident (i.e. Natural causes)	0	**4**	0	**8**
Death - Caused by patient safety incident	0	**1**	0	**4**
Moderate -Pt required further treatment or procedure	2	**14**	0	**4**
Low - Minor harm	28	**110**	16	**193**
None - No Harm / Injury	133	**337**	73	**489**
Suffolk	**30**	**282**	25	**529**
Death - Not patient safety incident (i.e. Natural causes)	0	**1**	0	**7**
Death - Caused by patient safety incident	0	**2**	0	**2**
Severe - Permanent or long term harm	0	**0**	0	**1**
Moderate -Pt required further treatment or procedure	2	**8**	1	**7**
Low - Minor harm	0	**45**	2	**117**
None - No Harm / Injury	28	**226**	22	**395**
Totals:	193	**748**	114	**1227**

Severity Reports

Shown nationally against other Mental Health Trust, Nation Reporting and Learning System NRLS historic data identifies the Trust as a high reporter (mostly in top 25%).

Our moderate recorded events are half of those recorded nationally. This data has been reviewed and in some cases where initially identified as moderate, i.e. client attended A&E with a suspected facture and on review no harm was found to have been done.

Since 1st October 2014 these type of events form part of 'Duty of Candour' arising from the Francis Report 'Hard Truths', in addition the investigations undertaken by the managing team and the communication they undertake with the clients guardians, there is a requirement to apologies for the harm caused and ensure there are clear outcomes agreed with the client and/or their guardians. With the exception of SI investigations there were 5 events in February, a further 7 moderate events did not apply to duty of candour as they were not deemed patient safety harm events – these were checked by the Patient Safety Lead and Risk Manager.

Monitoring was also conducted to assure that no harm and low events hadn't increased after investigation. The process is currently being audited by the Trust Internal Auditor.

2 CONCLUSION

The committee is asked to receive the risk report for information and discuss any concerns in trends to be reported back to the Service.

Neil Paull
Head of Risk and Security management

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Quality Governance Committee (QGC)
Meeting Date:	March 2015
Title of Report:	Complaints
Action Sought:	For Information
Estimated time:	
Author:	Michael Lozano, Patient Safety and Complaints Lead
Director:	Jane Sayer, Director Nursing, Quality and Patient Safety

Executive Summary:

To inform the Committee of the Trust's performance relating to complaints management.

Issues reported on:

- Number of complaints
- Complaints by area
- Response performance
- Learning from resolved complaints

1.0 Report contents

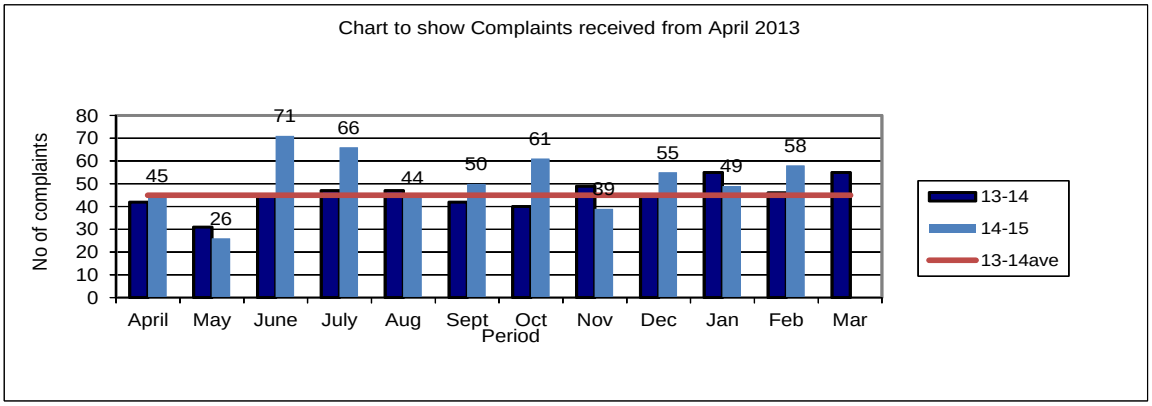
Key Headlines

1. The number of complaints during February 2014 shows an increase of nine on January 2015 (from 49 to 58).

2.0 Complaints report

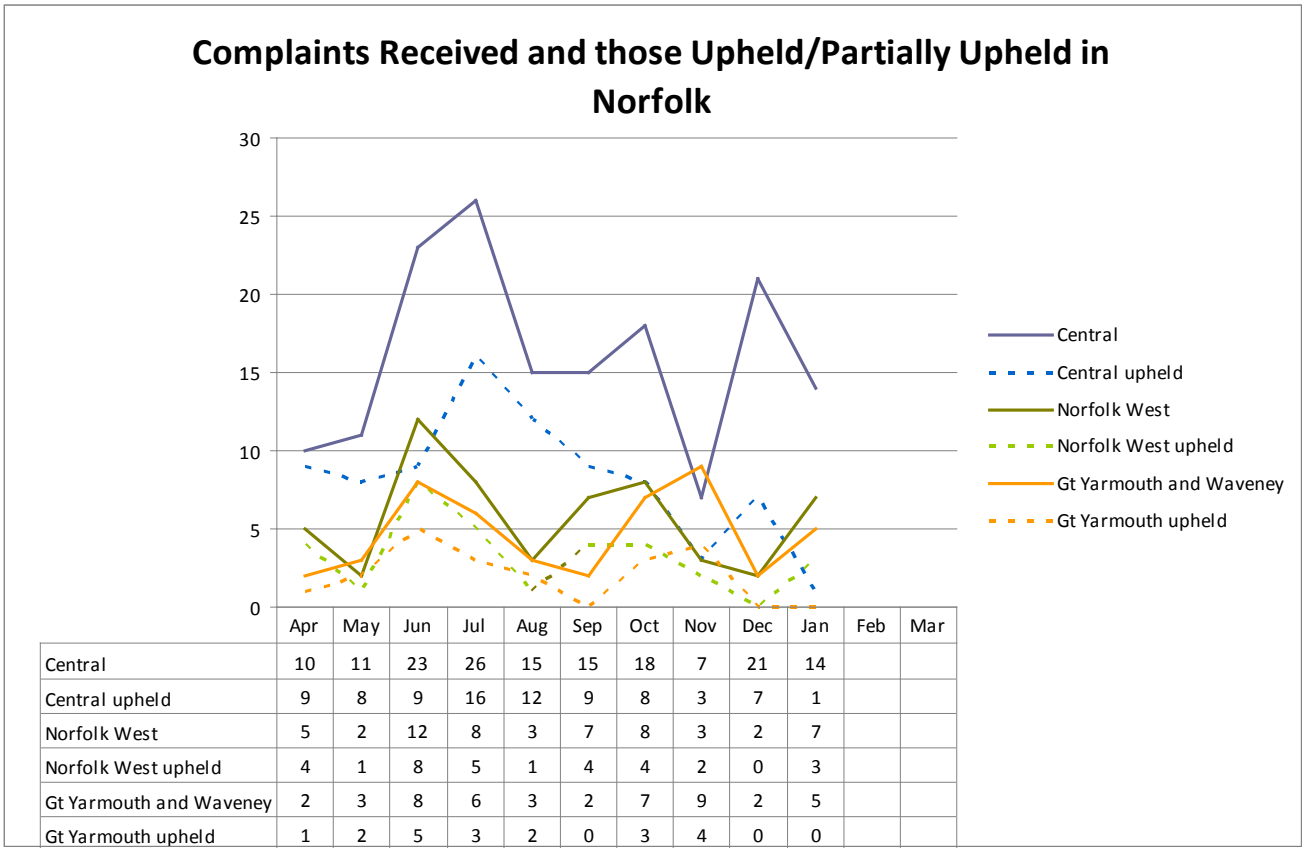
2.1 Number of Complaints

There were 58 complaints received during February 2015.



2.2 Complaints data

The following graphs/charts show the number of complaints received each month from April 2014 to January 2015 with the corresponding number of complaints upheld or partially upheld. The upheld/partially upheld line will change over time as complaint responses are completed and therefore acts as an indicator and not a confirmed figure. This will most likely affect the previous three months.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Central	10	11	23	26	15	15	18	7	21	14		
Central upheld	9	8	9	16	12	9	8	3	7	1		
Norfolk West	5	2	12	8	3	7	8	3	2	7		
Norfolk West upheld	4	1	8	5	1	4	4	2	0	3		
Gt Yarmouth and Waveney	2	3	8	6	3	2	7	9	2	5		
Gt Yarmouth upheld	1	2	5	3	2	0	3	4	0	0		

Identification of trends

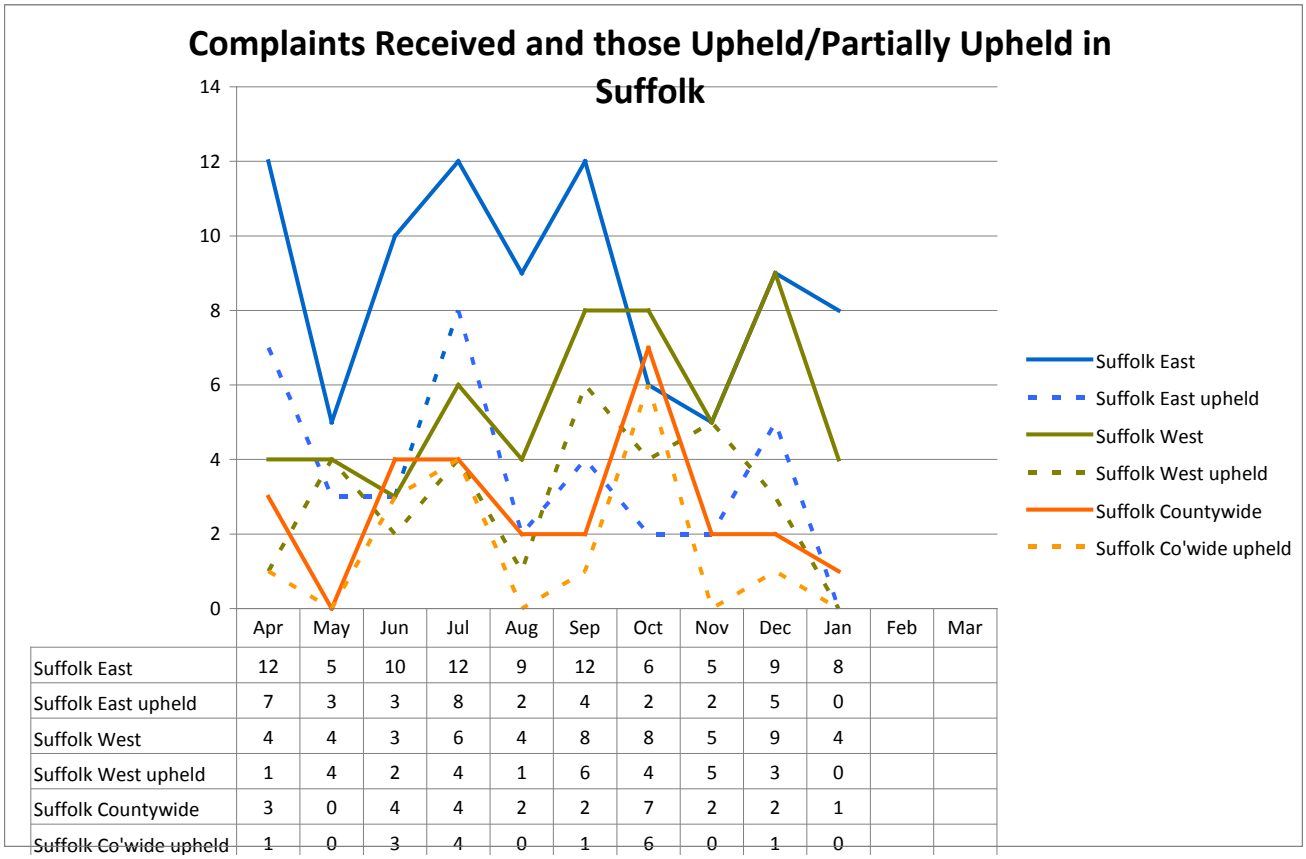
For Central Locality the graph showed a sharp increase in complaints in June and July 2014. Review of these complaints showed ten related to Rollesby ward. The complaints ranged from missing personal items, access to cigarettes, access to their own food, and

incident requiring staff intervention. The upheld complaints included an incident of administration of the wrong dose of a medication to the patient. There was no assessed harm as a result. The Trust followed its medication error process.

A subsequent spike in complaints was noted for December 2014 (21). None related to Rollesby ward. The area with a sharp increase was South Norfolk Community Mental Health Team with ten complaints. Of those responded to an upheld complaint responded to a patient's request to see a different clinician after stating they had trouble understanding their previous clinician. The other partially upheld complaint was included an aspect of the personal budget process.

For Norfolk West Locality an increase in complaints in June was noted (12). Six of these referred to the Community Mental Health Team with a theme around communication between clinicians, patients and their carers. Of the seven complaints in January four referred to the Community Mental Health Team. Whilst some are being investigated at this time, the complaints register difficulty with being allocated a care worker and response from team to the individuals needs.

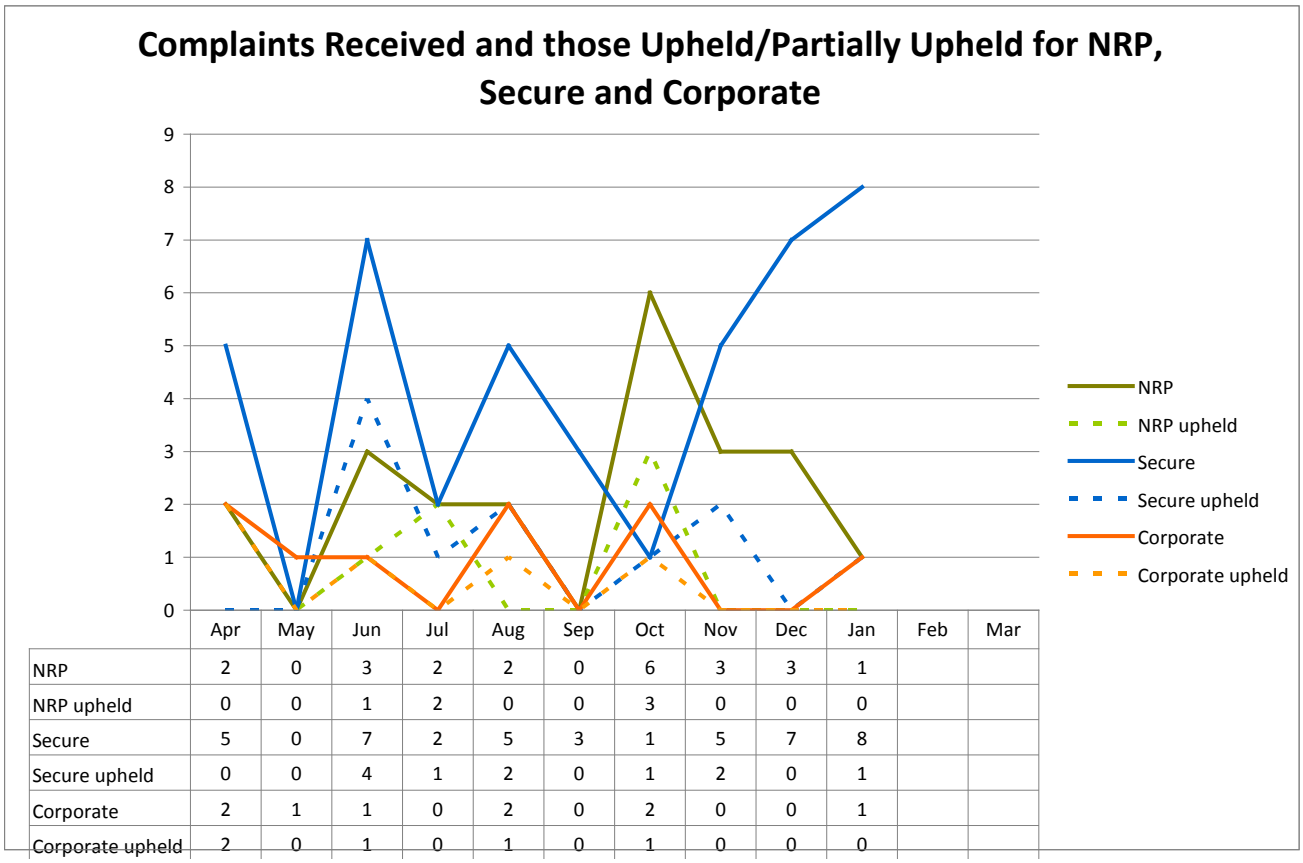
For Great Yarmouth and Waveney Locality October and November 2014 showed an increase in complaints. Three related to Waveney Recovery Team including the complainant registering concern at the length of time to receive an appointment.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Suffolk East	12	5	10	12	9	12	6	5	9	8		
Suffolk East upheld	7	3	3	8	2	4	2	2	5	0		
Suffolk West	4	4	3	6	4	8	8	5	9	4		
Suffolk West upheld	1	4	2	4	1	6	4	5	3	0		
Suffolk Countywide	3	0	4	4	2	2	7	2	2	1		
Suffolk Co'wide upheld	1	0	3	4	0	1	6	0	1	0		

Identification of trends

Suffolk East and West saw a rise in complaints in December 2014. These were in relation to a number of teams, with no single one receiving significantly more than others.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NRP	2	0	3	2	2	0	6	3	3	1		
NRP upheld	0	0	1	2	0	0	3	0	0	0		
Secure	5	0	7	2	5	3	1	5	7	8		
Secure upheld	0	0	4	1	2	0	1	2	0	1		
Corporate	2	1	1	0	2	0	2	0	0	1		
Corporate upheld	2	0	1	0	1	0	1	0	0	0		

Identification of trends

Secure Services saw an increase in December and January. Some of these complaints are currently being investigated. One related to the family member stating they felt unsupported by staff in addressing concerns they had about the patient. An apology was provided as staff would not offer the names of the senior managers to whom they could take their concern. Staff have been reminded it is appropriate to provide manager's names.

2.3 Process and outcomes

Of the 58 complaints received in February 2015 two have been closed, one at the request of the complainant and one closed as it concerned another agency. Upon initial receipt of the complaint it is not always clear which organisation the complaint is in regard to.

In total during February 2015 46 complaints have been responded to (including complaints received in previous reporting periods). 11 have been upheld, 13 partially upheld, 13 not upheld, three closed at the request of the complainant, three closed as the patient confidentiality form was not returned, one closed as the summary was not returned and two closed as they concerned another agency.

Of the 46 complaints closed in February 37 received written responses. Of these 10 were responded to within 30 working days, 13 were responded to within 31 to 40 working days and 12 were responded to between 41 and 100 working days. Two took over 100 working days.

Of the twelve responses which took over forty one days to be completed, the delays have been identified as the following;

Three were delayed by awaiting the complainant return of either the subject of the complaint's consent or a signed copy of the summary of their complaint. A new process in now in place within the Patient Safety & Complaints Team which acknowledges this delay with regards to measuring Trust response times.

A further two were delayed by queries and requests for further information to be added to the response, identified as a result of the quality checking process.

Two were delayed by the investigator trying to make contact with or waiting to meet with the complainant to clarify prior to responding to their concerns.

Two were accounted for by the same complainant registering multiple complaints. Staff regularly met with the complainant to clarify and address each concern as it arose prior to responding with confirmation of the agreed actions.

One was delayed by a Complaints Team internal processing error.

One was delayed due to the complainant raising additional concerns requiring response during the late stages of the investigation.

Finally, one was delayed by the complaint response requiring the completion of a professional investigation before it could be finalised.

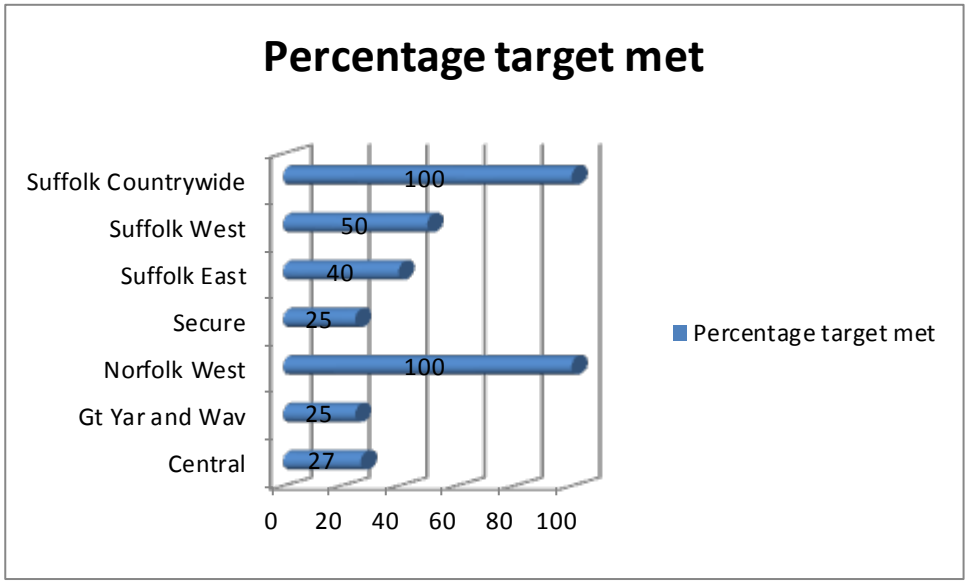
To confirm the measurement point. The response date used to calculate the response time is the one on which the letter is posted to the complainant. This could be different to the date on which the Chief Executive signed the letter.

	Within 30 working days	31 to 40 working days	41 to 100 working days	Over 100 working days
Number of complaints responded to	10/37 27%	13/37 35%	12/37 33%	2/37 5%

Draft Responses

In order to meet the 30 working day time target for providing a complaint response, draft responses are requested to be sent to the Patient Safety & Complaints Team from the investigating manager within 20 working days of the receipt of the complaint. This is to allow for time to quality check the complaint, address any issues and complete sign off with the Chief Executive.

The percentage of the 37 complaints receiving written responses during February that met this target is shown below:



This is the first time of reporting this measure. It is acknowledged this indicator does not yet account for complaints that are significantly complex and have extensions in order to support a complete investigation.

Further it should be noted this reflects the draft responses received against a time point but does not show whether the draft is returned to the investigating officer for further investigation or clarification. The Patient Safety & Complaints Team is working on a secondary measure which will indicate whether further work on a draft response is required, giving an insight into the quality of the draft responses.

Learning relevant for other services:

Nine complaints closed in February relate to attitude of staff. Of these five were upheld or partially upheld (where the complaint comprised of different concerns, some of which were upheld).

The five responses to those upheld or partially upheld contained apologies issued in relation to staff appearing dismissive due to concerns over restrictions of what the clinician can say in relation to information sharing concerns, appearing to be sarcastic and not divulging information of who ward managers were when asked. All the responses offered assurance of learning outcomes generated by the complaint including Therapy Teams working with Ward Staff to develop skills in managing challenging symptoms, reflection by staff in supervision sessions, refreshing of information to staff concerning what information can and cannot be divulged under certain circumstances and assurance that concerns have been taken seriously.

Six complaints closed in February relate to interventions provided by CRHT services across the Trust. Of these three were upheld or partially upheld.

The three responses to those upheld or partially upheld contained apologies for poor communication between a duty worker and CRHT, including an explanation of a duty worker's role and purpose and of referrals between teams and their timeframes. An apology was made for the complainant being given incorrect information by the Care Coordinator regarding access to CRHT telephone support. Information was provided to

some complainants regarding the new support line provided by the Trust in collaboration with MIND, which is an intervention to complement the work of CRHT.

Acknowledgement was made of concerns raised holding a common theme of a lack of communication, both between services and service users/carers and assurances given that communication is a topic the Trust continues to review and address.

2.4 The Parliamentary and Health Service Ombudsman

During February 2015 one complainant has taken their case to the Ombudsman.

During February 2015 no complaints were concluded by the Ombudsman.

3.0 Local Development

No local developments to report.

4.0 National Developments

No national developments to report.

Norfolk and Suffolk NHS
NHS Foundation Trust

Workforce Performance Dashboard - Locality Breakdown

February 2015

	Sickness Absence (rolling			Turnover Rate			Vacancy Rate			Appraisal		Mandatory training	
Locality	Monthly Value	Change	Target*	Monthly Value	Change	Target*	Monthly Value	Change	Target*	Value	Change	Value	Change
Central Norfolk	5.16%	0.01%	5.11%	16.82%	0.44%	15.23%	8.50%	-0.35%	10.83%	73.97%	2.21%	66.37%	11.37%
Great Yarmouth and Waveney	5.43%	0.36%	5.11%	11.39%	-0.14%	15.23%	5.25%	-1.11%	10.83%	58.18%	4.30%	67.32%	8.32%
Norfolk West	5.04%	-0.25%	5.11%	21.70%	1.61%	15.23%	12.38%	1.01%	10.83%	84.05%	8.70%	70.18%	9.18%
Norfolk system	**5.23%**	**0.15%**	**5.11%**	**15.59%**	**4.45%**	**15.23%**	**7.97%**	**-0.41%**	**10.83%**	**69.76%**	**2.76%**	**67.18%**	**8.85%**
East Suffolk	5.05%	0.06%	5.11%	12.59%	0.18%	15.23%	7.86%	-0.32%	10.83%	91.32%	3.47%	76.15%	6.15%
West Suffolk	4.94%	0.31%	5.11%	17.97%	1.30%	15.23%	16.36%	0.34%	10.83%	67.66%	4.56%	67.47%	7.47%
Suffolk Wellbeing	5.55%	-0.35%	5.11%	9.26%	0.17%	15.23%	5.38%	-0.19%	10.83%	100.00%	0.00%	79.52%	16.52%
Suffolk A&A	6.75%	0.73%	5.11%	11.29%	1.77%	15.23%	13.37%	-2.68%	10.83%	99.29%	-0.71%	68.16%	4.16%
Suffolk System	**5.17%**	**0.15%**	**5.11%**	**13.72%**	**0.98%**	**15.23%**	**10.80%**	**-0.24%**	**10.83%**	**87.32%**	**3.32%**	**73.76%**	**9.51%**
Secure Services	7.09%	0.16%	5.11%	14.47%	0.07%	15.23%	12.91%	1.66%	10.83%	69.87%	11.18%	71.28%	4.28%
Substance Misuse	4.73%	-1.29%	5.11%	15.09%	-0.29%	15.23%	12.21%	0.52%	10.83%	102.44%	19.31%	64.36%	21.36%
Specialist Services	**6.60%**	**0.41%**	**5.11%**	**14.78%**	**-0.08%**	**15.23%**	**12.77%**	**1.35%**	**10.83%**	**76.82%**	**8.82%**	**70.20%**	**15.20%**
Corporate Services	**3.46%**	**0.01%**	**5.11%**	**22.34%**	**1.63%**	**15.23%**	**19.93%**	**1.15%**	**10.83%**	**75.92%**	**8.22%**	**80.32%**	**24.32%**
Total Trust	**5.07%**	**0.09%**	**5.11%**	**16.03%**	**0.37%**	**15.23%**	**11.64%**	**0.14%**	**10.83%**	**75.25%**	**4.59%**	**71.97%**	**8.97%**

*In month target, based on trajectory to March 2016

Service in A&E following attempted suicide or self harm episodes

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

A report from Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospital NHS Foundation Trust, Queen Elizabeth Hospitals NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust on the protocols used when patients who have attempted suicide or self harm arrive in A&E.

1. Background

1.1 On 15 January 2015 Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'service in A&E following attempted suicide or self harm episodes' to its forward work programme. The subject was proposed in November 2014 by a member of the committee who was aware of local cases where patients and their families felt they were not met with understanding of mental health conditions in A&E.

1.2 Another councillor has raised cases where they believe that vulnerable individuals, who have attempted suicide, are released from hospital as soon as they are physically stable and without appropriate aftercare.

2. Purpose of today's meeting

2.1 The three acute hospitals and Norfolk and Suffolk NHS Foundation Trust (NSFT) have been asked to report to NHOSC on the protocols used by A&E departments and NSFT in circumstances of attempted suicide or self harm. Their reports are attached:-

Appendix A – Norfolk and Suffolk NHS Foundation Trust
Appendix B – Norfolk and Norwich Hospital - protocol
Appendix C – James Paget Hospital - protocol

The Queen Elizabeth Hospital (QEH) – to provide a verbal report at the meeting. NSFT's paper (Appendix A) includes details of the mental health liaison services provided at all three hospitals, including the QEH.

Representatives from each of the hospitals and NSFT have been invited to today's meeting to discuss the protocols and processes in use.

3. Suggested approach

3.1 After the hospital representatives and NSFT have presented their papers, members may wish to discuss the following issues with them:-

(a) There are variable levels of mental health support available at the three acute hospitals. Do the hospitals and NSFT consider that current levels are adequate?

(b) What training do all levels of A&E staff receive in treatment of people in mental health crisis at each of the hospitals?

(c) What do steps do each of the A&E departments take to ensure that patients who have attempted suicide or self harm are discharged to a safe environment?

(d) What steps are taken to involve the patient's family, friends or other support network in the discharge arrangements?

(e) After there has been an episode of attempted suicide or self harm that has resulted in attendance at A&E, what specific steps does NSFT take to reduce the likelihood of a recurrence?

Norfolk and Suffolk NHS Foundation Trust

Service given to patients with mental health issues in A&E following attempted suicide or self harm episodes

1. We have been working closely with the commissioner over the past 2 years to improve liaison services at our three acute hospitals and thereby improve the response to those presenting after deliberate self harm.

   In 2014/15 we have been working on a CQUIN (Scheme 7) to specifically improve understanding of the pathway for self-harm and provide education and training to raise public awareness and for other health professionals (Appendix i-iii).

2. James Paget Hospital
   There is a mental health liaison practitioner provided to JPH Monday to Friday (CQUIN Scheme). At other times the Crisis Resolution and Home Treatment Team in GWY respond to referrals from JPH and including those patients who present following incidents of self harm.

   There is a Norfolk Recovery Partnership (NRP) liaison practitioner based at the JPH enabling joint assessment to be undertaken where there is also a history of substance abuse alongside self harm.

   Onward referrals to or involvement of acute or community mental health services are dependent on the outcome of the initial assessment.

3. Norfolk and Norwich University Hospital
   There is a small seven day a week liaison service provided to the NNUH. We are currently seeking recruitment to extend the hours of operation up to 24/7 (pending successful recruitment).

   The service aims to respond to referrals from A&E for those considered medically fit for discharge within 1 hour. Assessments are conducted jointly with NRP practitioners when appropriate (i.e. substance abuse issues also present). Currently, out of liaison service hours, referrals are direct to the CRHT who provide a similar service to that at the JPH. (See Appendix iv for a copy of the NNUH Liaison Referral pathway).

   Onward referral to or involvement of acute or community mental health services is dependent on the outcome of the initial assessment.

4. Queen Elizabeth Hospital
   A liaison service was first established at the QEH in December 2013, funded from 2013/14 System Resilience funds. Funding was agreed for this service to continue throughout 2014/15 and contract negotiations are currently underway to secure liaison provision in 2015/16.

   The service is provided from 08:00 to 23:00, 7 days a week. The West Norfolk CRHT provides liaison cover from 23:00 to 08:00.

The QEH Liaison evaluation report completed in February contains an analysis of self-harm presentations at A&E during 2014 (Appendix v)

List of Appendices

A&E Mental Health Liaison and Self-harm pathway developments in 2014-15
(appendices attached)

No.	Title
i	CQUIN Scheme 7: Self-Harm
ii	Presentation to staff at QEHKL by Liaison Psychiatrist, Dr. Laurence Potter (presented twice during 2014)
iii	Programme for the Self-Harm public workshop at the Professional Development Centre, Kings Lynn in September 2014.
iv	Referral pathway for NNUH liaison service
v	Queen Elizabeth Hospital Mental Health Liaison Team: Year 1 Evaluation Report

<table>
<tr><th colspan="3">SELF HARM</th></tr>
<tr><td>Indicator number</td><td colspan="2">7</td></tr>
<tr><td>Indicator name</td><td colspan="2">Self-Harm</td></tr>
<tr><td>Indicator weighting
(% of CQUIN scheme available)</td><td colspan="2">0.35%</td></tr>
<tr><td>Description of indicator</td><td colspan="2">To re-develop the pathway for the re-occurring/repeat self-harmers with the intent that self-harm cases will reduce.

To facilitate the training and education of a wide range of health professionals, to include GPs, Ambulance Clinicians and Allied Healthcare Professionals as appropriate across Norfolk (professional groups and disciplines engaged in the agreed training and education package to be reported quarterly).</td></tr>
<tr><td rowspan="2">Interdependences (Does this indicator have implications for other providers and does this pose a risk to the provider)</td><td>Yes/No
(Is there a risk to the provider if the other providers do not engage with this indicator)</td><td>Providers affected
(List the providers that should work with the provider to complete the indicator)</td></tr>
<tr><td>No</td><td>EEAST, NNUH, QEHKL, GPs</td></tr>
<tr><td>Numerator</td><td colspan="2">None - TBC for Q2</td></tr>
<tr><td>Denominator</td><td colspan="2">None - TBC for Q2</td></tr>
<tr><td>Rationale for inclusion</td><td colspan="2">The Royal College of Psychiatrists (2010) estimates that the incidence of self-harm in the UK has risen over the last 20 years and that the rates amongst young people are the highest in Europe.

In 2011/12 there were 439 admissions relating to self-harm in Norwich alone and in 2012/13, over an 11 month period there were 1901 attendances to the NNUH A&E department, costing £201,191; 952 of these attendees were admitted. From April 2012 – October 2013 there were 1454 admissions in Kings Lynn relating to self-harm.

These are significantly worse than the England average of 212 admissions in 2011/12.

The majority of these will be classed and coded as emergency admission by Secondary Care.</td></tr>
</table>

	The average Length of Stay (LoS) is currently being explored. A high number of these cases will be for the under 25 year old age group.
Data source	Data collection on assessments undertaken and appropriate interventions reported. • Training sessions developed and recording of attendance by Healthcare Professionals (Junior Psychiatrists and other staff groups). • Professional groups and disciplines engaged in the agreed training and education package to be reported quarterly.
Frequency of data collection	Quarterly
Organisation responsible for data collection	Each participating organisation to provide their own data set.
Frequency of reporting to commissioner	Quarterly - within 10 working days at the end of each quarter.
Baseline period/date	Not applicable
Baseline Value	Not applicable
Final indicator period/date (on which payment is based)	Q1 = 30%, Q2 = 20%, Q3 = 30% and Q4 = 20%.
Final indicator value (payment threshold)	Within 10 working days at the end of each quarter.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	**Quarter 1** – Scoping Exercise NSFT will provide the following information on: NSFT to lead the development of a project plan which will include: • A review of the current self-harm referrals, support pathways and developments required in order to meet the indicator. • Identification of the relevant professional groups and their training requirements to support the risk assessments of

	individuals who self-harm, and the plan for delivery of training sessions. • Develop the referral pathway and supporting systems for referrals and assessments of individuals which will provide identification of patients at high, medium and lower risk levels and the relevant response based upon the developed referral pathway. • Provide a baseline of the number of episodes of assessment and treatment which is currently provided to both inpatients and outpatients who self-harm. • Agree the outcome indicators to measure effectiveness of support being received by patients. *30% of the indicator weighting*. Final Q2, Q3 and Q4 outcomes to be agreed with Commissioner using the data from Q1. To consider pilots during Q2 and Q3. *If the Q1 evidence demonstrates that this indicator is viable then Q2, Q3 and Q4 will continue.* **Quarter 2** – NSFT will provide the following information on: 1. Implement professionals' training sessions and re-launch referral pathway. 2. Provide a progress report on implementation, numbers of training sessions being provided, attendance responses and summary of feedback from attendees regarding effectiveness of training. *20% of the indicator weighting*. **Quarter 3** - NSFT will provide the following information on:

	1. Analyse numbers of patients, appropriateness of referrals and assessed risk levels referred through the pathway and provide as part of a quarterly progress report around training, implementation of pathway and a qualitative/quantitative comparative on patients who are re-presenting with self-harm behaviour from baseline numbers. 2. An outlined business case proposal to demonstrate how this indicator will become business as usual in 2015/16 by 15/11/2014. *30% of the indicator weighting*. **Quarter 4** – NSFT will provide the following information on: 1. Provide a full review of the work undertaken as part of the indicator to provide comparatives to patient outcomes, numbers of repeat self-harm episodes and training provided and attended with recommendations for progressing work through 2015/16. *20% of the indicator weighting*.
Final indicator reporting date	April 2015
Are there rules for any agreed in-year milestones that result in payment?	Achievement of quarterly milestone will result in payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Negotiation re payment will be required if partial achievement of milestone is met.

Presentation to staff at QEHKL by Liaison Psychiatrist, Dr. Laurence Potter (presented twice during 2014)

Self-Harm

Dr Laurence Potter

Consultant Psychiatrist

Mental Health Liaison Team, QEH

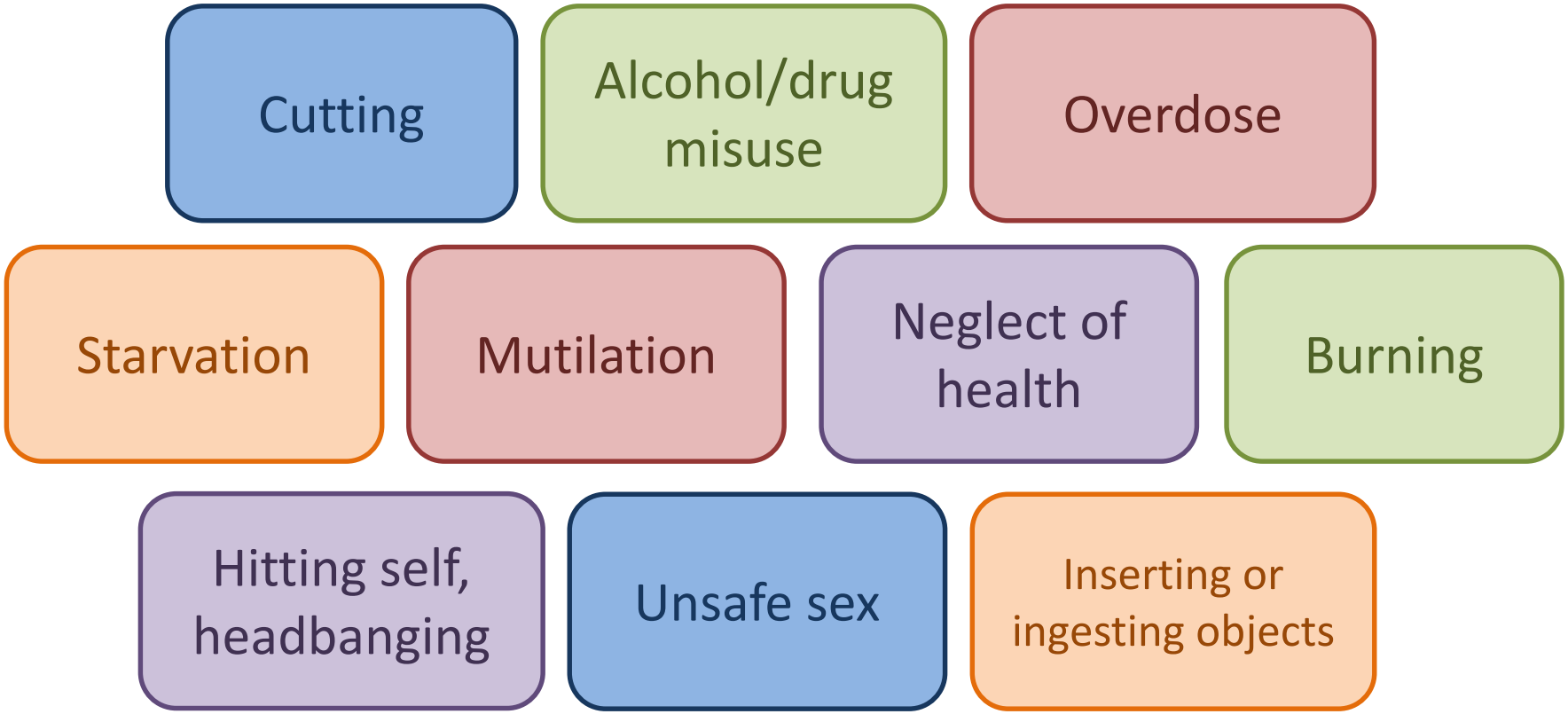
Introduction

- Background
  - What is self-harm?
  - Who self-harms?
  - Where does self-harm present?
  - Why do people self-harm?
  - When do people self-harm?
- Assessment
- Management

What is Self-Harm?

- ‘Self-poisoning or self-injury, irrespective of the apparent purpose of the act.’
    - National Collaborating Centre for Mental Health, 2004
- ‘Self-injury is frequently the least possible amount of damage and represents extreme self-restraint.’
    - National Self-Harm Network (NSHN; 1998)

What is Self-Harm?



What is Self-Harm?

- Self-injury is the commonest form of self harm
- Poisoning represents 80-90% of self-harm presenting to hospital
- If one form of self-harm behaviour is suppressed, another may emerge

Who Self-Harms?

- Anyone
- UK has highest rate in Europe: 400 per 100,000
  - Horrocks et al, 2002
- Increasing over past 20 years, particularly young men
- Top 5 cause of presentation to hospital
  - (but many do not present)
- 2/3 of those presenting are <35
- 2/3 of those presenting are female
  - M:F 1:5 overall
  - Fox and Hawton,2004
- Cutting not as predominant in females as previously thought
  - Lilley, 2008

Who Self-Harms?

- Unemployed, single, live alone, are in debt and have problems with alcohol
  - National Collaborating Centre for Mental Health, 2004
- Social isolation and breakdown in family and other personal relationships
  - Haw & Hawton, 2008
- Past sexual abuse
  - Bebbington et al, 2009
- In adolescents: sexuality, social problems, isolation, school problems, family problems
- Prisoners, asylum seekers, LGB, veterans

Why do People Self-Harm?

‘I don’t see it as a prelude to suicide;

I see it as a survival thing.’

‘In some ways it gave me control over the pain I felt, rather than having it inflicted on me by someone else, somehow inflicting harm on myself as I say, got me through the other afflictions […] it was just helping me through life in general.’

Why do People Self-Harm?

- "Maladaptive" coping mechanism in response to unbearable emotional distress
  - Punishment – confirming negative view of self
  - Numbness – grounding in dissociative state, pain feels "real", confirm existance
  - Relief – from feelings of anger or anxiety
  - Distraction – possibly from suicidal thoughts
  - Control – loss of control may exacerbate self harm
- Often provides temporary relief
- May be followed by shame or self-disgust

Motive	Self-cutting, %	Self-poisoning, %
Escape from a terrible state of mind	73.3	72.6
Punishment	45.0	38.5
Death	40.2	66.7
Demonstration of desperation	37.6	43.9
Wanted to find out if someone loved them	27.8	41.2
Attention seeking	21.7	28.8
Wanted to frighten someone	18.6	24.6
Wanted to get back at someone	12.5	17.2

Motives chosen by young people to explain reason for self-injury
Hawton et al 2006

Self-Harm and Mental Disorder

- Minority of people who self-harm will have a diagnosed mental disorder, but the prevalence of:
  - Mental illness 90%
  - Personality disorder 46%
    - Haw et al, 2001
- Strong association with borderline personality disorder
    - Klonsky, 2007
- Other diagnoses are also at a high level of risk:
  - Major depression, anxiety disorders, substance misuse, eating disorders, post-traumatic stress disorder, schizophrenia and other personality disorders

Self-Harm and Mental Disorder

- Intellectual disability
  - May be dismissed as “challenging behaviour”
  - Severity of harm related to severity of disability
  - Institutionalisation, abuse and neglect contribute
- Alcohol and substance misuse
  - Increased risk of suicide and self-harm
    - National Mental Health Development Unit, 2009
  - Risk of existing self harm increased when intoxicated or initiating treatment for dependence

When do People Self-Harm?

- Various triggers
  - Relationship difficulties
  - Social problems: benefits, housing
  - Re-experiencing trauma/flashbacks
  - Misinterpretation or assumptions

What Self-Harm Isn't

- A diagnosis or disorder
- A label
- The same for each person
- The same for each occurrence
- Necessarily attention seeking (most takes place in private)

Outcomes

- 30-fold increase in suicide risk
- Risk increased more in females than males
- Risk greatest within 6 months of self harm
  - Cooper et al, 2005
- For many it remains a secret until circumstances change or they “grow out of it”

Assessment Approach

- Empathic, non-judgmental listening
  - Reflecting back to patient
  - Marked but sincere
- Acknowledging patient's view of themselves and the world
  - Attending hospital may be difficult
  - Recognise stigma
- Gently challenge patient beliefs
  - Alternative explanations or suggestions
  - "Own" alternatives
- Reflect on own emotional response
  - Individual and team support

Risk Assessment

- Distinguish between Acute and Chronic Risk
- Intent/reason for self-harm
  - May need to ask specifically about suicidal intent
  - If self-harm has reduced distress, immediate risk of self-harm is reduced but risk of repeating is increased
- Trigger – has this been resolved?
- Severity vs perceived severity

Risk Assessment

- Check any care plans
  - Avoid rushing patient, may not feel listened to
- Protective factors
  - Clear management plan
  - Therapeutic optimism
  - Alternatives
  - Support

Management - Immediate

- Follow crisis plan if available
  - Feedback to MHLT if crisis plan is not working
- Treat physical health needs
- Referral to Mental Health Liaison Team for concurrent assessment
  - “Fit to assess” not “fit for discharge”

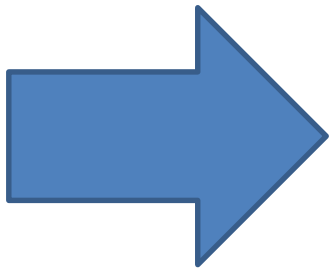
Management - Immediate

- Encourage patient to take responsibility for treatment plan if possible
- Consider use of Mental Capacity Act for short term incapacity, e.g. intoxication
- Consider use of Mental Health Act to detain if there is evidence of an underlying mental disorder needing assessment or treatment

Management – Medium Term

- Alternate coping strategies
- Little evidence for specific treatments for self-harm
  - CBT
  - Problem-solving therapy
- Use dynamic crisis plan
- Involve and support carers where appropriate
- Treatment of underlying MH problems
- Harm minimization

Assuming
Reacting



Understanding
Planning

Understanding and Managing Self Harm

September 24th

Programme of Events

9.15 Welcome and Introduction
- by Marcus Hayward, locality manager

9.30 'What is Self Harm?'
- by Dr. Laurence Potter, consultant psychiatrist

10.00 Avouchments
- a personal perspective

10.30 'Managing Self Harm'
- by Helena Crockford, consultant psychologist

10.00 Coffee break
- with the Cookie Monster

11.15 Norfolk Recovery Partnership
- with Katie Walker, counselling psychologist

11.30 West Norfolk Mind
- with Eddie West-Burnham, CEO

11.45 Recovery
- by Maggie Harrison, modern matron

12.00 Plenary and Reflection
followed by cold lunch

Limited spaces available at Kings Lynn location.
RSVP deborah.jordan@nsft.nhs.uk or 01553 736068
Thank You

mind for better mental health

Norfolk Recovery Partnership

Norfolk and Suffolk NHS
NHS Foundation Trust

Youth Council

Referral pathway for NNUH liaison service

Liaison Psychiatry – Referral Pathway

Patient requires liaison psychiatry opinion / input

Check that patient has had relevant investigations and work-up

Consider optimum timing for the referral
(for example patient is now sober, conscious and able to communicate)

All referrals should be made online to Mental Health Liaison using ICE, with a clear statement of the purpose of the referral including any specific questions and desired outcomes

The Liaison Team will then allocate an appropriate clinician to respond to the referral.

If urgent, or further discussion needed, then please:

1. Liaison Team bleep 0910; or if not possible
2. Contact Ext 4686 (Liaison Team Leader DECT phone); or if not possible
3. Contact us on Ext 2825 (leave message if no answer)

Dr Julian Beezhold, Consultant Liaison Psychiatrist, is now part of the team until end March 2015 and may be contacted as above. This does not change the referral pathway.

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	West Norfolk Clinical Commissioning Group
Meeting Date:	Various
Title of Report:	Queen Elizabeth Hospital Mental Health Liaison Team: Year 1 Evaluation Report
Purpose of the Report:	Evaluation of efficacy and inform commissioning priorities for 15/16
Estimated time for item:	20 minutes
Author:	Marcus Hayward, West Norfolk Locality Manager
Director:	Debbie White, Director of Operations for Norfolk & Waveney

Introduction

- This evaluation report provides a summary and conclusions from an in-depth analysis of Liaison Team activity in 2014 and in some instances includes January 2015.
- When relevant (e.g. D8 breaches) this activity is benchmarked against similar activity information for 2013.
- For ease of reference, the section numbers in the main report (pages 1 to 6) correspond to the numbered sections in appendix 1 (pages 7 to 16).

1.0 Liaison Team Referrals & Assessments

1.1 Referrals to Liaison Team

The QEHKL experiences a high number of mental health related attendances in A&E. Referrals to the liaison team in 2014 totalled 992, averaging 83 per month.

1.2 The importance of changing custom and practice within the local health system in West Norfolk to reduce the number of mental health attendances at the QEH is recognised by the West Norfolk System Resilience Group.

1.3 Although the total referrals in the last 3 months of 2014 (216) were 92% of the referrals in the first 3 months (236), the intervening months saw an average referral rate 113% higher than January to March. This fluctuation in referrals does appear to be a seasonal effect and further attention is required to address the high referral rate.

1.4 Under-reported referrals

94% of all logged referrals are from the Emergency Department, with only 6% from other areas at the QEH. However, it is very apparent from verbal reports and other anecdotal evidence that the Liaison Consultant Psychiatrist in particular is very busy responding to 'Green Card' requests to see patients on wards at the QEH.

1.5 The Consultants activity within the A&E has been captured, but many of the referrals and subsequent assessments of inpatients have not been captured and there is therefore an underreporting of inpatient referrals and subsequent clinical contacts.

1.6 Attendance / referral activity by day of week

There is a statistically significant peak in referrals during mid-week, with referrals on Wednesday 165% of the average referral rate over the weekend.

1.7 Attendance / referral activity by time of day

The liaison team works extended hours, from 08:00 to 23:00. Skeleton cover is provided from 23:00 to 08:00 by the CRHT. It is noteworthy that there is not a peak in referrals between 08:00 and 10:00, but rather a gradual climb in referral activity peaking during late afternoon and early evening with 27% of all referrals received between 16:00 20:00 hours.

1.8 This 24 hour referral trend validates the decision made at the commencement of the liaison team to forgo 24/7 cover in favour of increasing available resources during the second half of the day.

1.9 Referrals by gender

54.6% of referrals are female and 45.4% male which concurs with the evidence base that seeking help for mental health problems is slightly weighted towards the female population. However, there is a greater biased when looking specifically at referrals involving self-harm (see Section 4).

1.10 Mental Health Assessment and Treatment Activity

At 1,148 the number of assessment and or treatment contacts in 2014 exceeded the number of referrals by 156 or +16%. The primary reason for this being when a further period of assessment is required either by a different team member / profession or following obtaining further relevant information.

1.11 83% of all assessments involved Mental Health Practitioners. 11% of recorded assessments required Consultant Psychiatrist involvement and 16% input from the team's AMHP.

1.12 Liaison Team AMHP

The AMHP is full time but 0.2 WTE of her working time is taken up with NCC hosted AMHP rota duties. This means that direct liaison time is equivalent to 0.8 WTE.

1.13 Requesting a MHA assessment via NCC duty AMHPs, primarily based in Norwich, frequently results in long delays and high risk of serious extended breaches occurring.

During 2014 the team AMHP has completed 5 MHA assessments while on liaison duties. On one occasion on a Friday this enabled a fast track transfer to Churchill Ward of an inpatient at QEH. Had this MHA assessment request gone via the NCC's EDT it would have had to wait until after the weekend.

1.14 KPI Performance

80% of referrals from A&E are seen within an hour of the referral, compared with a KPI of 90%. However, this improves to 90% of referrals seen within 2 hours.

The referral response to logged referrals from elsewhere at the QEH shows performance exceeding target with 99% of patients referred from MAU and Terrington Ward seen within 24 hours, 60% from other Wards and 100% seen within 3 days.

1.15 Substance Abuse

29% of all referrals are assessed as involving substance abuse with most (20%) due to alcohol.

1.16 Self-harm

Between March and December 2014, 44% of all referrals included aspects of self-harm. Further analysis of 242 self harm referrals is provided in section 5.

2.17 Outcome of Assessments

The outcome in 9% of referrals was admission to a non-QEH bed, including acute mental health inpatient bed on Churchill Ward, Fermoy Unit, a bed elsewhere in NSFT or an out of area bed. Also included in this 9% are specialist placements (e.g. mother and baby unit) as well as transfer to local general hospital for patients out of their home area.

1.18 35% of referrals had no previous contact with mental health services recorded, whereas 41% did have a record of previous contact but where not active at the time of attendance. Approximately half of these were referred on to another mental health service including Norfolk Recovery Partnership, providing community drug and alcohol services. 24% of referrals were found to be already active to a mental health service and the relevant team / care coordinator or lead care professional recorded on the system were informed of the attendance.

1.19 In total 36% required no immediate follow-up and were provided with advice and signposting information before being discharged.

2.0 Mental Health Related (D8) Breaches

2.1 D8 (Psychiatric Assessment) breaches in A&E have reduced from an average of 16 per month between April 2013 and January 2014, to just under 8 per month for the period since the liaison team became fully operational in February 2014 to date. This equates to a **52% reduction** in the average rate of D8 breaches.

2.2 There has been a large increase in the proportion of D8 breaches resulting from self-referrals to A&E, increasing from 38% in 2013 to 54% in 2014.

2.3 There is also a significant increase in the proportion of D8 breaches that arrived by ambulance, increasing from 47% in 2013 to 59% in 2014. The proportion of arrivals with police involvement also increased from 9% to 13%.

2.4 However, the biggest reduction of arrival method in D8 breaches was by private car or taxi, reducing from 40% in 2013 to just 24% in 2014.

2.5 The change in the D8 profiles suggest that the team is effectively reducing breaches resulting from self-referral. Whereas those with greater complexity, requiring ambulance or police attendance are proving more difficult to overcome.

3.0 QEH Frequently Attending and Admitted Patients (System CQUIN)

3.1 During the period from March to December 2014, 81% of referrals were for individuals with only one recorded referral, and in 13% of cases there were 2 referrals.

3.2 However, the other 6% (39) service users had between them 148 separate referrals / attendances during the same period.

3.3 As part of the System CQUIN for 2014/15, the liaison team have identified 15 frequently attending patients who are responsible for a total of 345 unplanned attendances in 2013 and 14. (See Appendix 1, 3.7)

3.4 The team are facilitating a variety of interventions following a recent re-attendance to ensure that the right support is in place to reduce repeat attendances in the future.

3.5 The attendance activity for 6 months before and 6 months after the intervention is being captured and although, for those whose interventions came later in 2014, the 6 month period is still running, the indications are that this approach has had a very positive impact. **To-date the attendance activity following the intervention is 63% less than it was for the 6 months before the intervention**.

3.6 Admission activity is also being monitored and shows in the 15 FAPs subject to close monitoring a 40% improvement in the number of admission / anticipated admissions following intervention (32) compared to the same period before the intervention (53).

3.7 The approach taken with FAPs, as reported in our Quarterly West Norfolk CQUIN submissions will continue and become a business as usual function for the liaison team.

3.8 Admission Avoidance Support Packages (West Norfolk Mind)
In 2014 a total of just over 1,010 hours of support has been provided to 52 service users with a range per individual of between 101 and less than 2 hours and averaging 19.5 hours per person.

3.9 Mind workers are partners of the liaison team and attend weekly team meetings to discuss service users with whim they are working and potential referrals. Provision of AASPs is considered in every FAP that becomes known to the liaison team.

4.0 Self-Harm (Local CQUIN)

4.1 Self-harm: numbers presenting
As stated in 2.6 above, between March and December 2014, 44% (363) of all referrals (833) included aspects of self-harm. A further analysis of 542 referrals has been completed, of which 242 (44.6%) involve self-harm.

4.2 Self-harm: types
84.7% of the self-harm referrals involved a drugs / medication overdose with 1.7% of these also including another form of self-harm. The next biggest category was deliberate cutting in 5.4% of referrals.

4.3 Self-harm: gender
62% of the self-harm related referrals were female, which is 7.4% higher than reported for all referrals (see 1.9).

4.4 Self-harm: age
Overall, self-harming incidents reduce with age, but the analysis of the self-harm presentations at the QEH provides evidence of some very notable peaks in self harming.

4.5 There is a high peak of self-harm presentations in those aged 16 to 20, accounting for 14% of all such referrals. This occurs again in those aged 46 to 50, which is an age group that also accounts for 14% of referrals. Those aged 41 to 55 accounted for more than 1 in 3 of all the self-harm related referrals that were analysed. A final smaller peak occurs in those aged between 71 and 80 which accounted for 8% of these referrals.

4.6 This analysis of self-harm presentations will inform information for health professionals being developed in 2014/15 Q4, as well as a review of pathways for self-harm impacting on all three service lines (CFYP, Adult, DCLL).

5.0 Dementia Assessment and Support

5.1 There is very little direct information available about NSFT activity for people with dementia at the QEH. However, the liaison team as well as other non-liaison clinicians at the QEH can refer directly to the Dementia & Complexity in Later Life (DCLL) and Dementia Intensive Support (DIST) Teams.

5.2 The liaison Consultant Psychiatrist is duel qualified in adult and old age psychiatry. There is anecdotal evidence that he has provided much input and support to help QEH manage people whose physical health management needs are complicated by a dementing illness.

5.3 The QEH's Clinical Nurse Dementia Specialist has direct access to the Consultant, as do the QEH's own consultants who continue to use the informal 'Green Card' system. Unfortunately this has bypassed the liaison teams business (activity) reporting procedures and this has contributed to the dearth of information required for this section.

5.4 However, the DCLL Service Line referral activity shows that referrals have continued at a high level throughout 2014, with the total in the last 3 months (510) 111% of those in the first 3 months (461).

5.5 Reviews of the dementia pathways in West Norfolk are continuing, but it is very apparent from the growing demand trend that services are reaching the limit of their current capacity and that additional resources are required.

6.0 Education and Skills Development

6.1 The liaison team work closely with QEH staff, particularly with QEH's own mental health clinical nurse specialists and within the Emergency Department. An element of education and skills development is implicit in their interactions with colleagues.

6.2 In addition to this implicit work, the team's consultant psychiatrist as conducted the following sessions at the QEH specifically on the subject of self-harm:

- 13/08/14: 6 attendees (all QEH A&E medical staff);
- 19/09/14: 30 to 40 mixed QEH staff attended, but predominantly doctors. 80% scored this session as 5 (the highest rating / very good) and 20% rated it as 4.

6.3 A larger stakeholder event was held at the PDC on 24/9/14, also on the subject of self-harm. This was co-delivered by mental health staff, West Norfolk Mind, and service users. The aim was to promote understanding and awareness of self-harm issues in mental health, reduce stigma, increase skills for workers, service users and carers, and promote discussion regarding current care pathways. The event was widely publicised and attracted approximately 50 attendees (including QEH hospital staff).

7.0 Conclusion and Recommendations

7.1 Whilst D8 breaches have been reduced by 52% to the pre-liaison team levels, there has been no discernible reduction in mental health attendances at A&E other than what could be expected from seasonal variations.

7.2 The increase in the proportions of self-referral attendances that result in a breach (37% in 2013 to 54% in 2014) together with the high number of referrals with a record of previous contact with mental health services but not currently active, suggests this may be a consequence of poor community provision and crises response.

7.3 It is clear from this evaluation that the QEH continues to require a robust Liaison Service. However, it is also apparent that the demand on this service is partly a consequence of pressures elsewhere in the system that urgently needs addressing.

7.4 It is therefore recommended that there is a particular focus in 2015 on the precursors to A&E attendance for those with mental health needs, and especially for those known to mental health services, which accounts for 65% of all referrals to the liaison team.

7.5 This will necessitate a review of Adult Community Team care coordination capacity, the establishment of a Flexible Assertive Community Treatment (FACT) function and ensuring the Crises Resolution and Home Treatment Team has adequate resources to provide 24/7 emergency response to community based referrals.

7.6 Consideration should also be given to the greater alignment of the Liaison Team and CRHT to enable pre-conveyance community outreach in response to alerts by the emergency services (e.g. Ambulance, Paramedics, Police).

7.7 This may result in some redirection of liaison team resources towards supporting the under pressure community services.

7.8 It is recommended that high level discussion take place with the QEH to agree a shared funding arrangement to enable robust liaison to continue, including increasing the Consultant Psychiatrist liaison resource from 0.5 to 1.0 WTE.

APPENDIX 1

QEH Mental Health Liaison Team Activity Analysis

Data Sources used in this evaluation

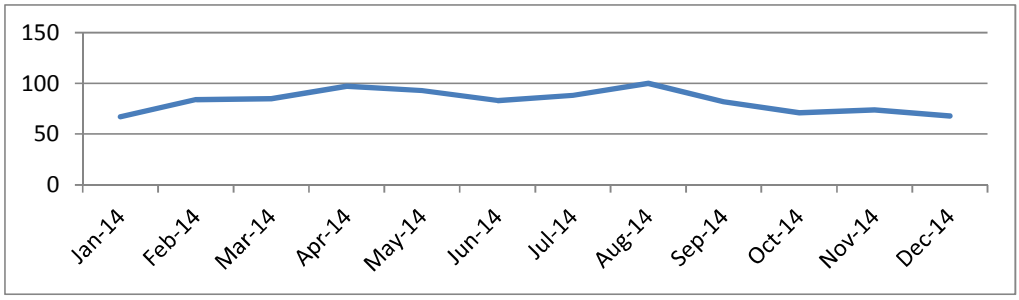
Information to inform the following sections 1 to 5 has come from the following sources:

- Patient referral and contact activity in 2014 from Maracis, the current electronic patient information system (to be superseded by Lorenzo from 20th April 2015);
- A manually compiled liaison team referral spreadsheet with information about source of referral, summary of issues (including self-harm presentations) and outcomes for referrals from March to December 2014;
- Anonymised D8 Breach Information (April 13 to January 15), provided by QEH;
- Manually collected information about frequently attending patient interventions and outcomes provided by the Liaison team and Mind;
- Ad hoc information provided by the Liaison Team and Mind to evidence specific elements of team activity (e.g. non-duty AMHP MHA assessments; teaching activities; AASP activity).

1.0 Liaison Team Referrals & Assessments

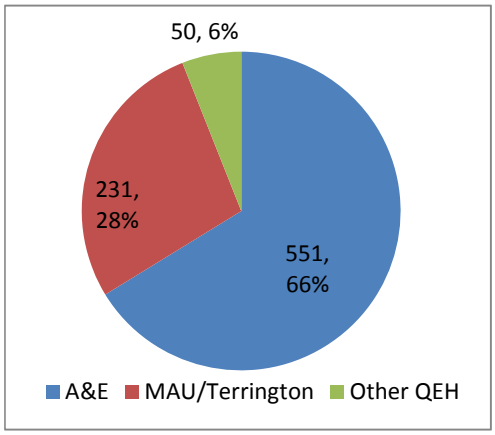
1.1 Referrals to Liaison Team

The Liaison Team received 992 recorded referrals in 2014 with a range from 67 to 100 monthly:



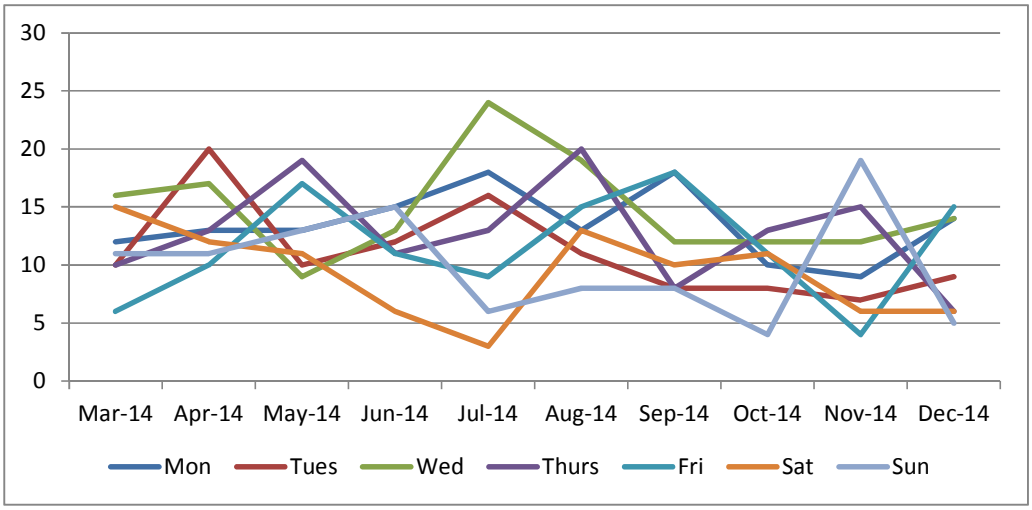
1.2 There is more detailed information for 833 referrals received between March to December 2014. This has been used to inform 2.4 to 2.9 and 2.10 to 2.14.

1.3 Source of referral

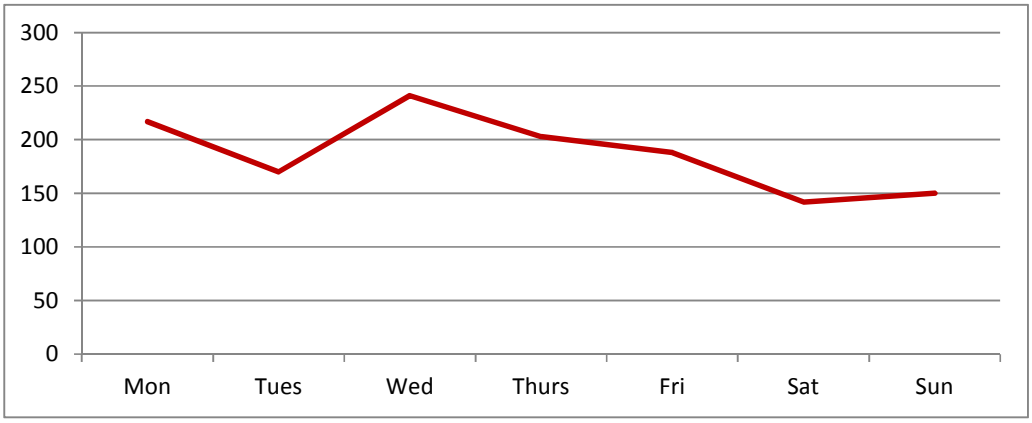


1.4 Attendance / referral activity by day of week

By month (March to December 2014):

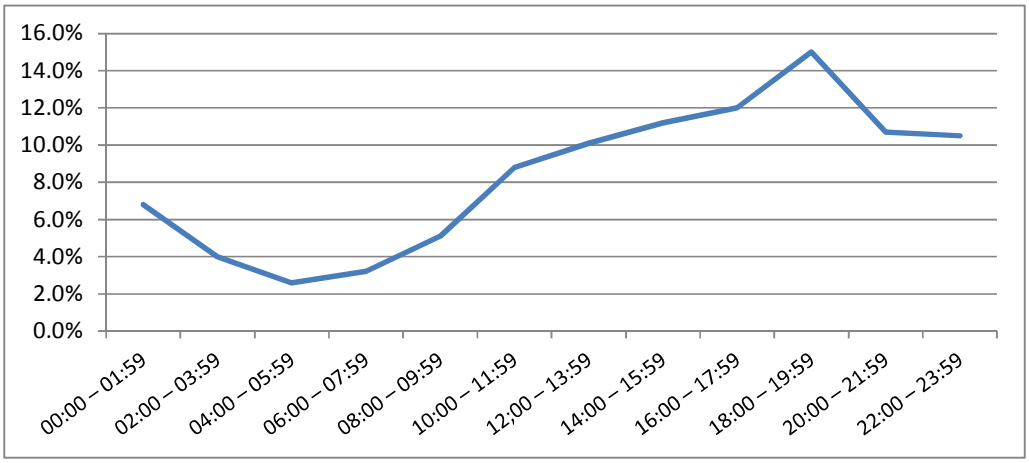


1.5 All March to December 2014 referrals by days of the week:

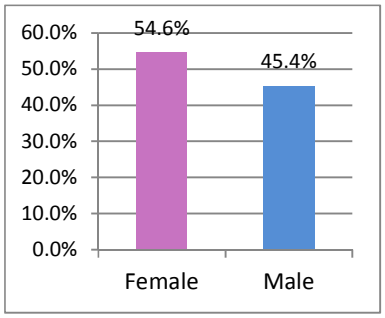


1.6 Attendance / referral activity by time of day

Time of A&E attendances (when recorded) that resulted in referral to Liaison team (as percentage of all (466) when time of arrival known):

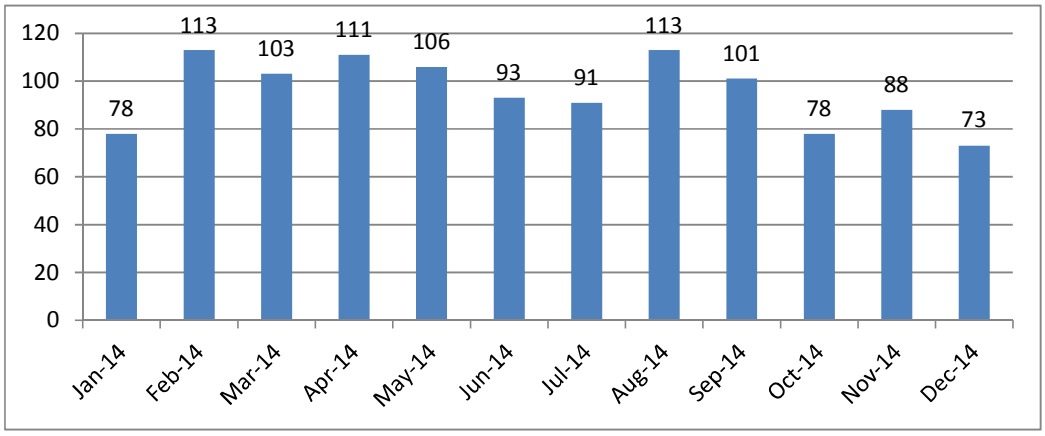


1.7 All referrals (March to December) by gender



1.8 Mental Health Assessment / Treatment Activity

In 2014 (January to December) there were 1,148 attended assessment and treatment contacts as follows:



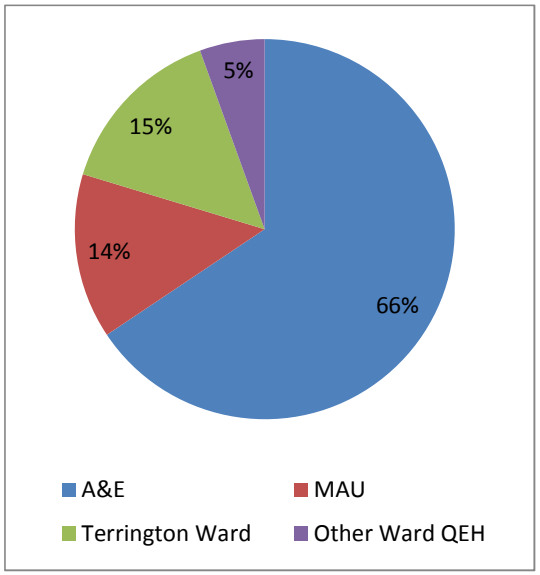
1.9 Referral to assessment KPIs

Department	<1 hour	<2 hours	<3 hours	<1 day	<3 days
A&E	**90%**				
QEH Ward				**50%**	**90%**

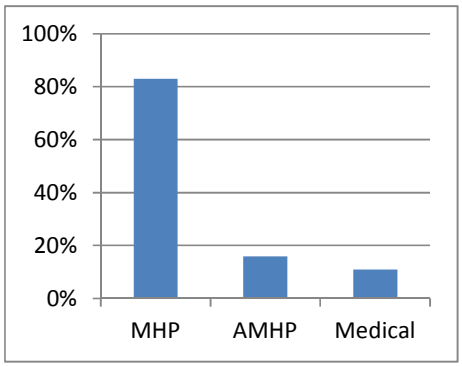
1.10 Referral to assessment performance

Department	Total #	<1 hour	<2 hours	<3 hours	<1 day	<3 days
A&E	**548**	**79.56%**	**89.78%**	**92.15%**		
MAU / Terrington	**232**	**46%**			**99%**	**100%**
Other QEH Ward	**50**	**38%**			**60%**	**100%**

1.11 Location of Assessment

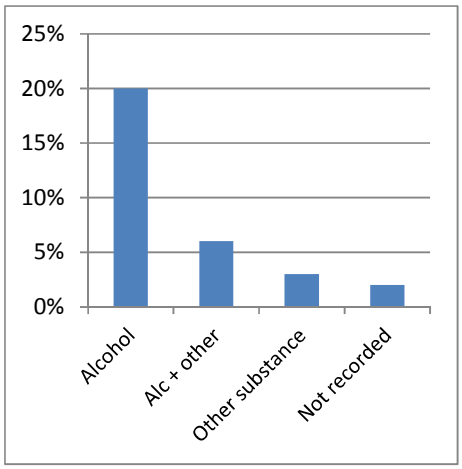


1.12 Practitioner involvement in assessment



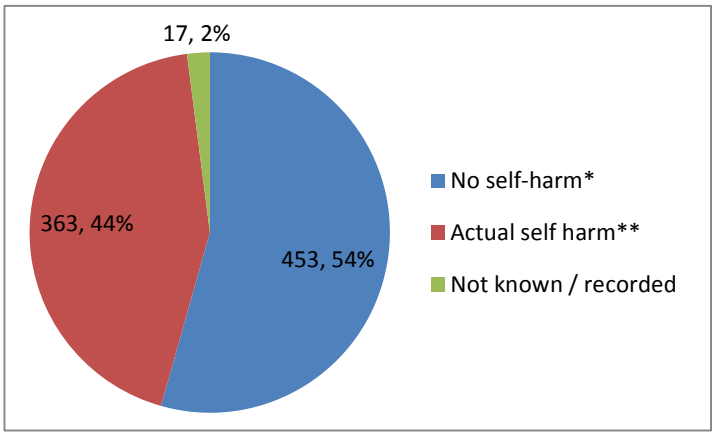
1.13 Substance Abuse

In 29% of assessments undertaken between March and December 2014, substance abuse was detected, as follows:



1.14 Self-harm

Based on information from all referral from March to December 2014:

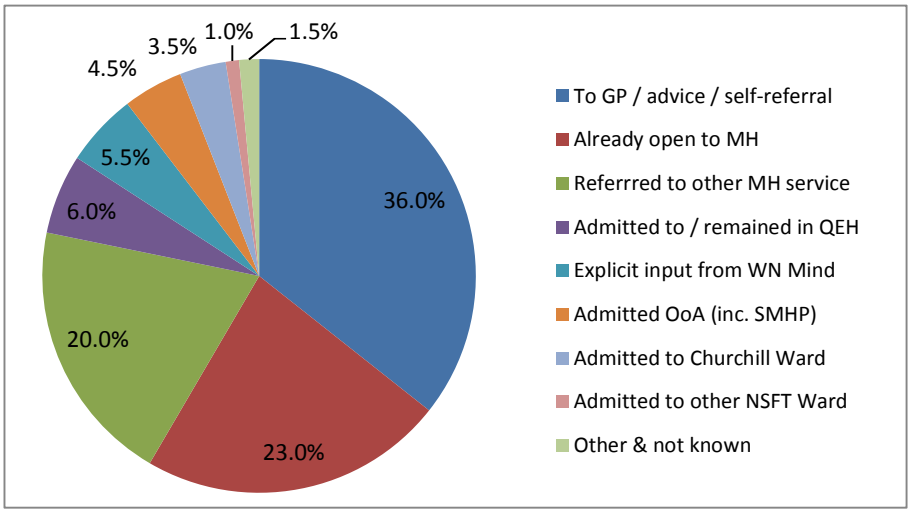


* includes threats to self-harm / suicide, but no evidence of actual self-harm

** Includes OD (over counter, prescribed or illicit), poisoning, ligature, cutting, etc.

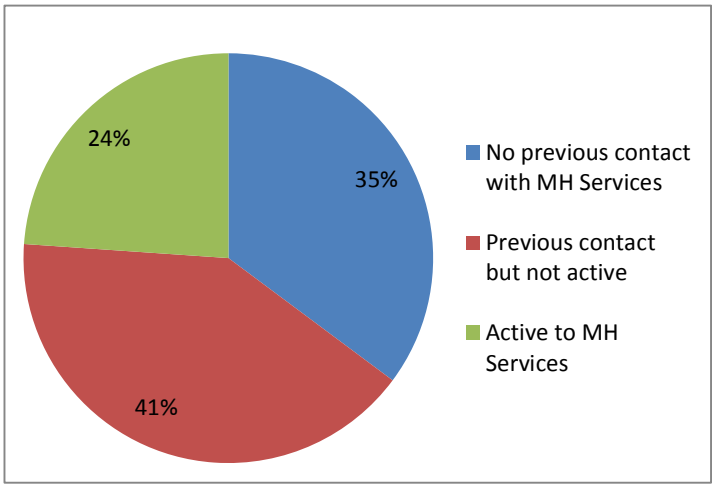
See section 4 for further analysis of referrals involving self-harm.

1.15 Outcome of Assessments



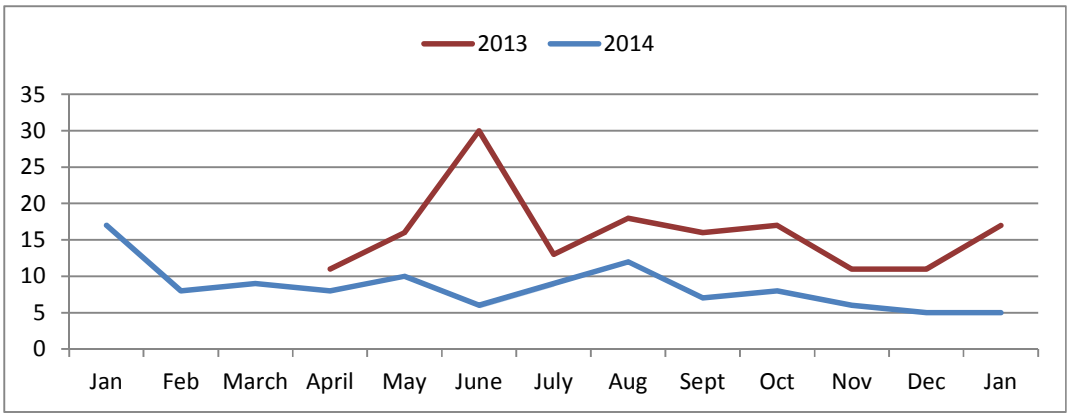
Of the 833 referrals from March to December 2014 analysed, 76 (9%) required an acute mental health assessment bed (Churchill Ward, OoA placement, Other NSFT Ward).

1.16 Previous / current mental health service involvement



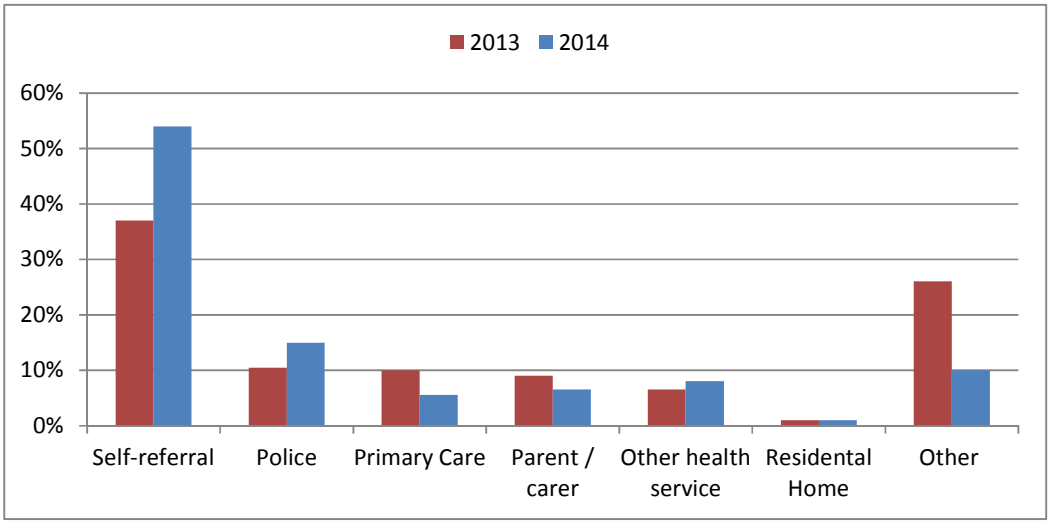
2.0 Mental Health Related (D8) Breaches

2.1 Breach trends from April 2013 to December 2014:

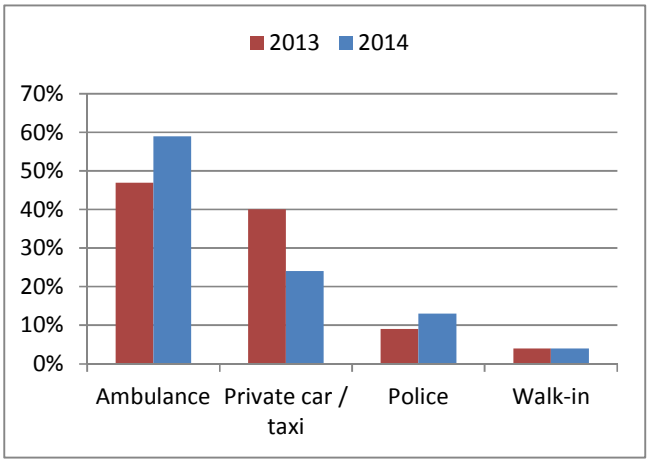


2.2 From April 13 to January 14 there were a total of 160 recorded 'D8 psychiatric assessment' breaches averaging 16 per month. During the 12 months from February 14, when the liaison team was first fully operational to January 2015, there have been a total of 93 D8 breaches, averaging just under 8 per month.

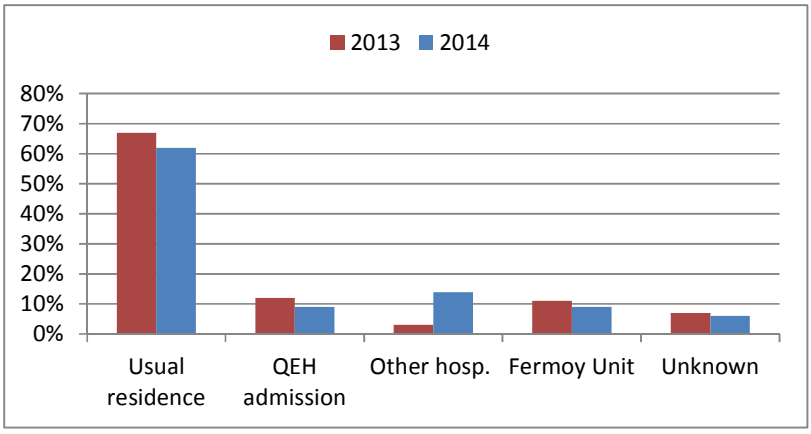
2.3 <u>Source of referral to A&E of all attendances that result in a beach</u>



2.4 <u>Method of arrival</u>

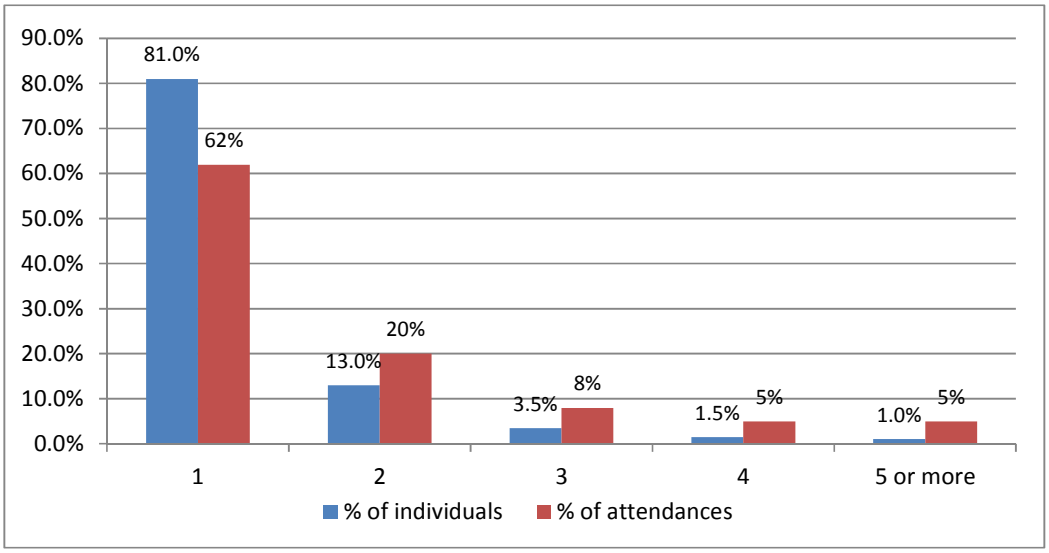


2.5 Destination following D8 breach



3.0 Frequently Attending Patients (System CQUIN)

3.1 Number of attendances by individuals (of all referrals, March to December 2014)



3.2 A total of 641 individuals were referred to the Liaison team. Of these:

- 81% (517) had only the single attendance / referral;
- 13% (85) had 2 attendances / referrals;
- 3.5% (22) had 3;
- 1.5% (10) had 4;
- 1% (7) 5 or more.

3.3 In total 6% (39) individuals were responsible for 23% (148) of attendances.

3.4 As part of the System CQUIN in 2014/15, the liaison team identified 15 frequently attending patients with a total of 197 attendances in 2014.

3.5 These FAPs received targeted interventions and a comparison of attendances for 6 months before the intervention and 6 months following.

3.6 The following table provides FAP activity and outcomes to-date (4.7).

3.7 QEH FAP Activity Table

Patient ID	Date of Intervention	Type of intervention	Agencies involved	Attendances pre-intervention[1]	Attendances post-intervention[2]	Admissions pre-intervention[1]	Admissions post-intervention[3]
01	Feb-14	Detox	Liaison, NRP	13	5	5	2
02	27/02/14	CRHT input	Various 24 hour supported care due to complex physical health needs.	6	7	0	1
03	10/03/14	Professionals meeting	Liaison, Mind, NRP, Ambulance, Police, NSFT Acute Service	16	10	9	5
04	13/03/14	CMHT referral	Discharged from services	14	3	5	0
05	17/04/14	MIND ref	Liaison, NRP, Mind, Probation	3	4	1	1
06	10/06/14	Professionals meeting	Liaison, NRP, Mind	10	4	3	1
07	04/08/14	Professional meeting	Liaison, AAT, APMHP	6	0	2	0
08	13/08/14	Liaison Assessment	Liaison, CRHT Adult social services	5	1	2	0
09	26/08/14	crisis planning	Mind, Adult recovery Liaison, GP	8	2 (to-date)	3	2
10	Oct-14	Professionals meeting	Liaison, NRP	22	6 (to-date)	6	8
11	08/10/14	Professional meeting	Liaison, RATS, Social services, Mind, NCH&C	9	0 (to-date)	5	0
12	20/10/14	Assessment in A&E and MIND referral	Liaison, Red Cross, RATS, Mind, NCH&C.	11	6 (to-date)	6	12
13	04/11/14	Professionals meeting	Liaison, Acute & Adult Community, Police, Housing, Council, NRP, Adult Social Care, Mind	6	1 (to-date)	2	0
14	26/11/14	Professional meeting	Liaison, Acute Services NRP	8	1 (to-date)	8	0
15	21/12/14	MHA Admission	Not open to services	4	2 (to date)	2	0
			Total attendances:	**141**	**52**	**53**	**32**
			Total percentage:	**100%**	**37%**	**100%**	**60%**

[1] For 6 months before date of intervention

[2] For 6 months after date of intervention (or to-date if less than 6 months)

[3] Number of actual or estimated admissions for 6 months after date of intervention

3.8 FAP attendance and admission activity continues to be monitored.

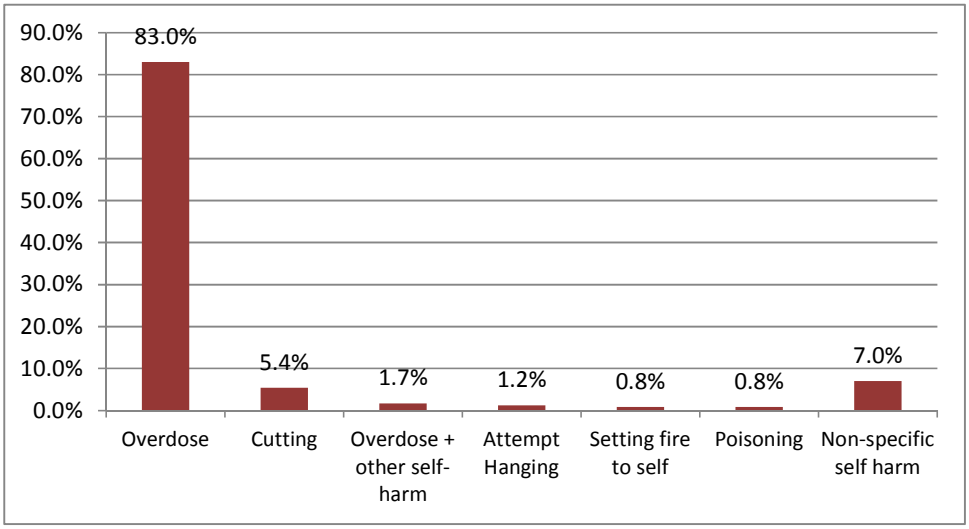
4.0 Self-Harm pathway (Local CQUIN)

4.1 Self-harm: numbers presenting

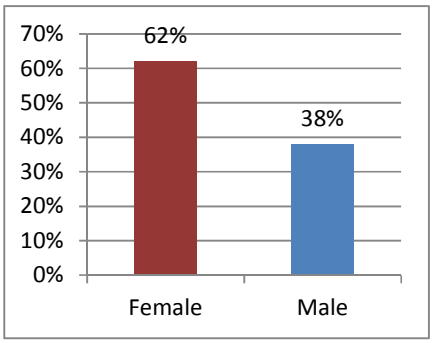
Of the 833 referrals between March and December 2014, 363 (44%) are recorded as having elements of self-harming present at the time of their assessment (see 1.14).

4.2 A more in-depth analysis of 542 referrals has been completed, of which 242 (44.6%) met the criteria for self-harm.

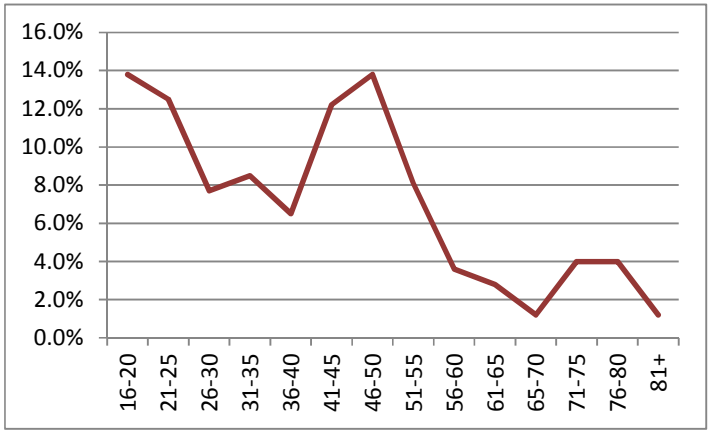
4.3 Self-harm: types



4.4 Self-harm: gender



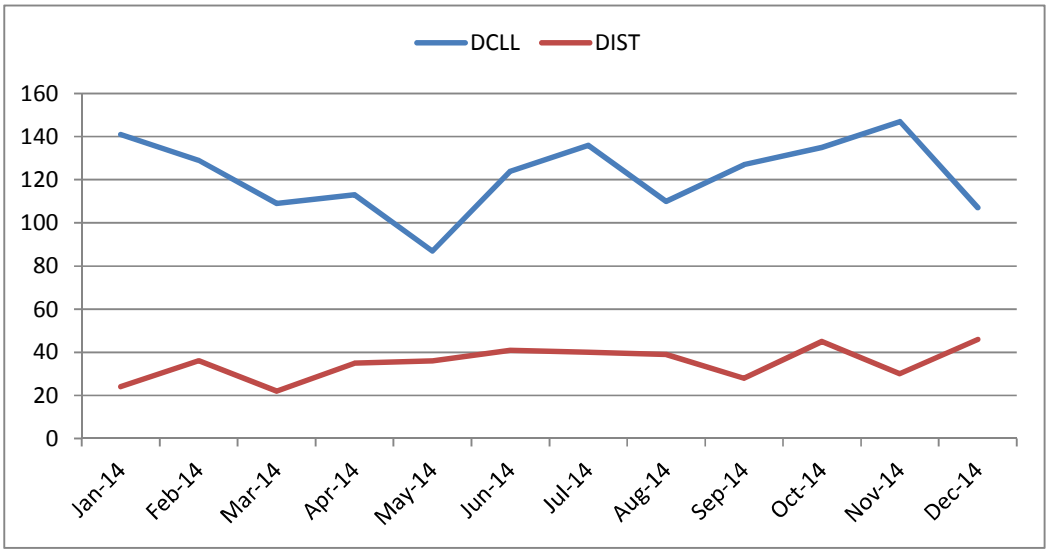
4.5 Self-harm: age



5.0 Dementia Assessment and Support

5.1 There is very little direct information available about NSFT activity for people with dementia at the QEH. However, the liaison team as well as other non-liaison clinicians at the QEH can refer directly to the Dementia & Complexity in Later Life (DCLL) and Dementia Intensive Support (DIST) Teams. These teams are part of the DCLL Service Line based at Chatterton House. Referrals have continued at a high level throughout 2014, with the total in the last 3 months (510) 111% of those in the first 3 months (461).

5.2 Referrals to the DCLL Service Line in 2014



Risk assessment and management of an adult patient who is at risk of deliberate self harm.

Post Holder Responsible for Policy:	Adult Safeguarding Lead & Risk & Patient Safety Lead
Directorate Responsible for Policy:	Trust Management
Date Written:	July 2012
Date Revised:	Jan 2014
Approved By:	PPPG
Date Approved:	Feb 2014
Next Due for Revision:	Feb 2015
Date Policy Becomes Live:	July 2012
For use in:	NNUHFT
For use by:	All trust staff
Keywords:	Self harm, Deliberate Self harm, Attempted suicide, Overdose, Emergency Mental Health Risk Assessment, Patient Environment Risk Assessment, Ligature

Version Information

Version No.	Updated By	Updated On	Description of Changes
1.1	Risk & Patient Safety Lead	Nov 2013	Revised Risk Assessment

Purpose of document

This policy and procedure provides clear guidance to staff in relation to providing a safe environment for a patient who is at risk of self harm. This includes the assessment of the risk and the management of the patient and includes guidance on the removal of items from the patient environment which could be used as a ligature.

CONTENTS

1. INTRODUCTION

1.1
Deliberate Self Harm is one of the top five causes of acute medical admission in the United Kingdom, as highlighted by the Royal College of Psychiatrists (2006). Good assessment of the likelihood of further self-harm is essential and a consistent approach is required to reduce the chance of self-harm being repeated in the future.

2. PURPOSE

2.1
The policy aims to ensure the safety of patients within Norfolk & Norwich University Hospitals NHS Foundation Trust (NNUHFT) clinical settings who present with Deliberate Self Harm (DSH) including risk of suicide or who give indication that they may attempt further deliberate self harm.

2.2
This policy applies to patients aged 16 years and above within all Trust adult in-patient and outpatient clinical areas. The majority of patients who have attempted suicide or who have deliberately self harmed (DSH) will present via the Accident & Emergency Department (A&E) however a patient may present with actual deliberate self harm or at risk of deliberate self harm within any Trust clinical area.

2.3
This policy and its related procedures does not relate to the clinical care and treatment of physical symptoms for the patient who presents with deliberate self harm. Staff must follow appropriate clinical care pathways and best practice protocols.

2.4
The purpose of this policy is to ensure that all Trust Health Care staff understand their role and responsibility in relation to the risk assessment and risk management of the patient who presents with deliberate self harm, including patients at risk of suicide or patients who give indication that they may deliberately harm themselves.

This includes:

1. DSH Risk Assessment of the emergency patient in the A&E
2. Patient Environment risk assessment for inpatients
3. Evaluation of the risk assessment and needs for further review / assessment
4. Specialist observational requirements of the patient as detailed within Trust Observation (Specialling) of Patients

3. ROLES AND RESPONSIBILITIES

3.1
Chief Executive
The Chief Executive has delegated responsibility from Trust Board for ensuring that the organisation meet requirements in respect of provision of a safe, appropriate environment which meets the needs of patients who present with deliberate self harm, ensuring the safety of staff in attendance of patients within this risk group.

3.2
Trust nominated Director for Safeguarding
The Trust nominated Executive Lead is the Director of Nursing and Safeguarding. They are responsible for ensuring that all aspects of this policy, its procedures and its training strategy are implemented Trust wide. The Executive Lead is also responsible for receiving reports related with this group of patients via at the Trust Safeguarding Adult Lead & Risk and Patient Safety Lead.

3.3
Trust Divisional Directors
Trust Divisional Directors are responsible for managing and organising resources in support of the implementation of this policy locally and for monitoring and reviewing divisional performance.

3.4
Responsibilities of the Clinical team within the Accident & Emergency Department
The clinical team in A&E are responsible for ensuring that an initial clinical assessment is undertaken and that and the patient is provided with any immediate treatment associated with their presenting clinical complaint.

The A&E assessing doctor / ENP is also responsible for the completion of an A&E Emergency DSH Risk Assessment (Appendix 1) and for acting on the results of the assessment unless this is clinically contraindicated e.g. patient unconscious.

The clinical team in A&E are also responsible for:

- Undertaking a further DSH Risk Assessment if the patients mental status is perceived to have changed e.g. increased vocalisation or physical manifestation of self harming intent.
- Undertaking an assessment of the patient's mental capacity at the time of initial presentation for the intention to further deliberately self harm – (see Mental Capacity Act policy)
- Referring the patient to the relevant mental health team resource dependant on the individual needs e.g. Mental Health Liaison Team.
- Agreeing an initial documented management plan in partnership with Mental Health services that meets the clinical needs and mental health needs of the patient.

3.5
Responsibilities of Site Management Team
The Site management team are responsible for the following:

- To liaise with the relevant medical/ nursing teams to identify the most appropriate inpatient placement area for the patient dependant on the clinical and mental health assessments
- Ensuring that the patient is placed in the safest possible clinical area based on clinical need, the Emergency DSH Risk Assessment and the Patient Environment Risk Assessment.
- Contacting / visiting the ward to realise any issues associated with the safety of the individual patient or other patients
- Ensuring safe and appropriate staffing is in place in response to the assessed level of patient risk.

- Escalation of any issues / concerns to the level of Divisional Director or Executive Director on call out of hours
- Providing ongoing support and guidance to the inpatient clinical team following the transfer of the patient from the A&E department.

3.6
Responsibilities of the Clinical team.

The Clinical team within all inpatient clinical environments other than in the A&E Department are responsible for ensuring that the following is implemented within 30 minutes of arrival on the ward:

- An environmental risk assessment is completed for the patient/ ward area to identify possible sources/aids for self harming behaviour (Appendix 2)
- Environmental risk assessments are updated for the patient/ward area if the patients mental status is perceived to have changed e.g. increased vocalisation or physical manifestation of self harming intent
- The patient is monitored/ observed in accordance with the DSH Risk assessment. Appendix 1.
- Comprehensive written documentation is kept by referencing the appropriate DSH Care plan. (High/ Medium/ Low Risk)

3.7
Responsibilities of all Trust staff
All staff within all clinical settings must understand their responsibilities, as appropriate to their role, in relation to this policy.

All staff must follow Trust standards for record keeping and adhere to professional codes of conduct.

3.8
Communications with patients and their carers
Staff must ensure that all patients and visitors are aware where there is an identified risk to the patient.

Staff should ensure that any items of personal possession or furniture / fittings which could be used as a ligature are removed from the patient's possession. Where possible, agreement of the patient must be gained, if this is refused, consideration should be given to the use of Mental Health Act in order to enhance the safety of the individual.

All communication and actions with relatives and carers must be documented within the patient's clinical notes.

4. DEFINITIONS

4.1
Deliberate Self Harm
Deliberate self-harm' means a self inflicted action a person does which causes them physical harm, but which is actually an expression of their emotional distress. Examples include:
- Cutting/ stabbing
- Burning

- Overmedication / ingestion of toxic substances
- Jumping from a height
- Inserting items into one's body
- Ligation/ self-strangulation

4.2
Adult
For the purposes of this policy an adult is an individual aged 16 years and above who is admitted to A&E or directly to an adult in-patient clinical setting.

4.3
Level of Deliberate Self Harm Risk – high/medium/low – see Emergency Mental Health Risk Assessment (Appendix 1)

4.4.
Definition of a Ligature
This is an item or a series of items that can be used to cause compression of airways, resulting in asphyxiation and death. The ligatures could be attached to ligature points i.e. from a window/door hinge. They also could be used manually by the individual.

Examples of ligatures could include belts, laces, torn sheets, equipment cables and oxygen and suction tubing. It is important to note that this list is not exhaustive and articles such as socks, handkerchiefs etc. can also be linked together to create a robust ligature.

Patients may be required to undergo both personal and possession searches to implement this Policy and Procedure.

It is the duty of all staff to clearly document in the clinical notes which items have been removed, providing a clear rationale for this and including a plan for on going monitoring of the situation. A decision to return a potential ligature must also be clearly recorded with evidence of the risk having changed being documented.

5. EMERGENCY DSH RISK ASSESSMENT

5.1
Emergency DSH Risk Assessment and Risk Categories

5.1.1
A&E staff who have received bespoke training will assess the patient using the Trust Emergency DSH Risk Assessment Tool, Appendix 2.

5.1.2
The Trust Emergency Mental Health Risk Assessment Tool will:

- Identify the patient's risk level
- Guide referral and risk management actions in response to the level of risk
- Ensure timely, appropriate referral, according to level of risk to the Mental Health Liaison Practitioner to enable a psychosocial assessment to be completed or to support referral to the Duty Psychiatrist in situations of emergency.
- Facilitate effective communication between the Emergency Department, admitting ward, wards at the point of patient transfer, Mental Health Liaison Nurse / duty

psychiatrist and any significant others, specifically with regard to the assessment of risk and recommended level of supervision/ observation required.
- Provide an appropriate level of observation and support for each patient.
- Clarify roles and responsibilities within the management process.

5.1.3
The Trust Emergency Mental Health Risk Assessment identifies three possible assessment outcomes, low/ medium/ high risk. Following completion of the Emergency DSH Risk Assessment Trust healthcare professionals must follow the actions as described relevant to their role.

6. PATIENT ENVIRONMENT RISK ASSESSMENT

6.1
The senior nurse responsible for the care of the patient at the time will assess the clinical environment using the trust template to prevent opportunities for further acts of self harm. The assessment of the patient's environment must give full consideration to potential use of equipment or other items which may result in the following:

- Strangulation or other potential ligature points
- Asphyxiation
- Sharps injuries
- Ingestion of toxic substances
- Jumping from a height

Emergency Department Staff must consider the environmental risks based on the 5 points above and record any necessary interventions.

The Trust template for Patient Environment Risk Assessment is found in Appendix 2.

7. CONSIDERATION OF MENTAL CAPACITY FOR PATIENTS PRESENTING WITH DELIBERATE SELF HARM

All Trust Health Care Teams involved in the management of patients presenting with deliberate self harm will assess the mental capacity of the patient. Staff must refer to the Trust Mental Capacity Act Policy.

7.1
LEGAL CONSIDERATIONS – Authority to remove items from a patient

Paragraph 25 of the Act (MHA 1983) Code of Practice, sets out the position regarding patient's who have capacity to give consent. If the patient refuses to give their consent to be searched for the purpose of ligature removal, this should be clearly documented within the clinical notes. Consideration should be given whether a police search is appropriate & would benefit the situation. Advice must be sought from the hospital Site Manager.

For patient's who lack capacity to give consent, or whose capacity is in question, the treating Consultant or the Adult Safeguarding Lead should be consulted for advice regarding whether it is appropriate to carry out the search.

Force should only be used in an emergency situation to ensure a patient's safety. At this point, assessment under the Mental Health Act should be undertaken and if necessary the patient transferred urgently to a mental health facility. It may be difficult to justify the use of

force where the procedure does not form a necessary part of the delivery of care and treatment for that individual service user. It may be appropriate to seek specific legal advice in cases where force is likely to be necessary. During working hours advice can be sought from the Trust Legal department or Local Safety Management Specialist.

Out of hours, the Site Manager must be contacted. Issues of concern will be notified to the Executive On-Call.

It is recognised that some patient's may require access to potential ligatures for the practice of their faith, i.e. wearing of turbans, crosses and amulets etc. Wherever possible, efforts should be made to allow the individual to retain these items. If risk assessment dictates otherwise, then discussion should take place with spiritual advisers to ascertain the availability of alternatives or use of the items during specific time periods or activities (i.e. during pray time). All these considerations / discussions need to be clearly documented within the clinical records.

The relevant Human Rights Act Articles and Protocols are –

- **Article 1** - This protocol requires the Trust to appreciate that every person is entitled to the peaceful enjoyment of their possessions and that no-one shall be deprived of their possessions except in the public interest and subject to the conditions provided by law.
- **Article 2** – Imposes a positive obligation on the Trust to protect life.
- **Article 3** – No-one shall be subjected to torture or to inhuman or degrading treatment or punishment.
- **Article 8** – Everyone has the right to respect for their private and family life, their home and their correspondence.
- **Article 14** – The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Article 14 is particularly applicable in relation to personal searches and the removal of property as interference with a human right must not be arbitrary and have a clear rationale for being undertaken. Any removal of property should not be undertaken, based on an individual's gender, sexual orientation, race or class. The rationale should always be documented.

7.2
Storage of property

- Where possible, any personal property received from the patient should be given to the patient's relatives for safe keeping and must be recorded in a property book.
- A receipt must be given to the patient and a copy stored in the book.
- Property must be returned within the shortest possible timescale.
- If a patient's property is to be stored outside of the ward the patient should be informed of where and how their property will be stored.
- A full explanation of the reason for removal of any personal items must be provided.

8. TRAINING

It is acknowledged that the Trust is not a mental health facility and does not have mental health as a primary function. As such specific training is provided to the medical and nursing staff who are associated with:

- Undertaking Emergency DSH Risk Assessment in A&E
- Site Managers undertaking environmental risk assessment
- Clinical staff who are involved in the observation & monitoring of patient's presenting with deliberate self harm

Frontline staff must also complete other aspects of violence/aggression, conflict resolution training as described in the Trust Mandatory Training Policy which is monitored as part of the Trust appraisal process.

9. DISSEMINATION

9.1
This policy will be shared with all staff and will be available via the Trust Intranet. It has been agreed by the Trust Safeguarding Adult Lead and the Risk and Patient Safety Lead, members of the PPPG Committee and reported to the Trust Clinical Governance Committee

10. MONITORING COMPLIANCE

10.1
Monitoring of this policy will be undertaken by an annual review of all cases of DSH and their compliance with this policy. The results will be reported to the Executive Director lead and disseminated to each Division.

11. ASSOCIATED TRUST POLICIES

This policy must be read in conjunction with the following policies:

- Mental Capacity Act
- Deprivation of Liberty Safeguards Process
- Missing Patient Policy
- Violence and Aggression Policy
- Clinical Records Keeping Policy

12. REVIEW

12.1
This policy will be reviewed annually in line with evolving National and Local Policy.

Appendix 1

Patient Environment Risk Assessment for a patient at risk of self harm / harm to others

What are the Hazards?	Who might be harmed and how?	What do you need to do?	Risk Rating and action HIGH	MEDIUM	LOW
Review the proposed environment for hazards (review management of other patients placed on ward to inform this) **e.g.** anything that a patient could use to cause harm to themselves – to include • **Ligatures** – e.g. oxygen tubing, call bell cords, telephone cords • **Plastic bags**, carriers that could be used for asphyxiation • **Sharp implements** – e.g. scissors, cutlery • **Toxic substances** for ingestion – e.g. alcohol gel • **Movable objects** that could be used to smash windows, mirrors etc. **Facilities** • Access to exits – risk of patient absconding • Access to other patients/ staff to promote conversation/ engagement • Location of toilet/ wash facilities • Refreshment facilities • Telephone facilities • TV/Radio	Consider who may be harmed in the event of further self harming event • Staff • Contractors • Patients • Visitors (review the placement of the patient on the ward to inform this)	**Consider what equipment** needs to be removed from the **bed space/ room/ area** that will not compromise clinical care while promoting well being for the patient .	**All**	**Some**	**None**
		Review placement of patient to enable • Observation • Interaction with other patients / staff • Access to exits on ward	**Constant** **None** **No access**	**Up to 1hrly** **Restricted** **Partial**	**Up to 4hrly** **Full** **Ful**
		Review impact of • Lighting • Temperature • Noise • Housekeeping • Decor			
		Ensure correct level & frequency of observation of patient • Observation (Specialling) of Patients • Mental Capacity Act	**Level 4/3** **Constant**	**Level 3/2** **Up to 1 hrly**	**Level 2/1** **4 hrly**
		Ensure correct observation of the patient • Frequency of observation	**Special 1:1**	**Close 1:2 or 1:6**	**Normal**
		Ensure ALL staff members involved in monitoring patient have a full understanding of their role	**Each shift**	**Daily review**	**At least Weekly review**
		Ensure that the correct security arrangements / facilities are in place regarding • Access/ egress control • Emergency alarms • Emergency procedure awareness (2222) • Security response • Window locks/ restrictors • Toughened / treated glass in windows / doors	**Each shift**	**Daily review**	**At least Weekly review**

Additional actions based on Risk Ratings

Actions for RED ratings - notify Ward manager / shift leader to review assessment and action plan each shift Escalate immediately to Lead Nurse/ Matron Share at ward handover. Review **each shift** or more frequently if situation changes.	**Actions ORANGE ratings** notify Ward Manager / shift leader to review assessment and action plan each shift. Escalate within one day to Lead Nurse/Matron Share at ward handover. Review **daily** or more frequently if situation changes.	**Actions YELLOW ratings** notify Ward Manager / shift leader to review assessment and action plan at least weekly. Share at ward handover. Review **weekly** or more frequently if situation changes.

Deliberate Self Harm (DSH) Risk Assessment Level of Supervision and Management required for all patient's assessed as at risk.

Level of Deliberate Self Harm Risk	Level of Supervision and Management criteria
HIGH Risk Patient will either – a) be admitted under the Mental Health Act (1983) b) have consented and agreed to be admitted informally c) be under the influence of a substance and unable to comply with risk assessment process due to lack of capacity at this time and admitted under best interests of the Mental Capacity Act pending risk assessment when the effects of the substance have resolved. **Possible mental health signs of risk** • Serious mental health problems present including possible features and symptoms of psychosis. • Patient may well have frank plans to engage in further self-harming behaviour, or to harm others. • Patient has clearly identifiable risk characteristics, such as imminent thoughts or plans relating to DSH or harm to others or suicide. • Patient may have already engaged in DSH behaviour and on-going suicidal intent remains. • Patient may lack capacity and competence to consent to or refuse on-going care and treatment. • Patient is considered likely to act upon thoughts of DSH at the earliest opportunity. • Mental state considered to deteriorate without intervention and will be vulnerable adult.	• Placement on ward that affords **maximum observation** (bed management/ ward team) • Bed environment assessed using Environment Risk Assessment/ Risk Management proforma (ward team) • Close supervision provided on one to one basis - a Registered Nurse (RN) or Registered Mental Nurse (RMN) should be requested. In the situation that a RN/RMN cannot be secured then a Health Care Assistant (HCA) trained in observations of self harming patients should be provided. • Patient must not be left alone in any circumstance • All ward staff must be aware of High Risk patients and the two levels of observation 'within eye sight' or 'within arms length' should be assessed by assessing clinician. • Comprehensive documentation/ observation must be recorded • The patient must not be allowed to leave the ward or to self discharge until full review by medical team and psychiatrist/ Mental Health Liaison Team. • If the patient attempts to leave the ward this must be responded to as an emergency. • The nurse in charge must inform – • ➢ Trust Security – using 2222 the Trust Security emergency response procedure • ➢ Trust Site Manager - Ext 6537 • Ward nursing and medical staff should take reasonable steps to detain the patient, maintaining the safety of staff, the patient and of other patients until the arrival of the Security team and the Site Manager on the ward and action taken in accordance with the Trust Missing Patient Policy. **The Patient must be referred to and reviewed by the Mental Health Team /Psychiatrist within 24 hours**

Date	Time	Comments

Patient Environment Risk Assessment for a patient at risk of self harm / harm to others

MEDIUM Risk a) All Deliberate Self Harm patients directly admitted through ED or current inpatient deemed to be at risk of DSH following deterioration in clinical condition. **Possible mental health signs of risk** • Patient has mental health problems and/or has non-specific thoughts or ideas regarding harm to self or others –e.g. regrets that SH failed to lead to death, but no intention to undertake further SH.	• Close observation and supervision by ward staff (30 minute checks both day and night) the patient must be observed by either a RN. If unavailable then a HCA trained in observations of self harming patients can be deployed. • Ward staff must be aware of Medium Risk patient and that intermittent observation as outlined in the procedure must be followed. Intermittent observations should not take place at same time each hour i.e. on half hour, timing should be varied so patient does not become reliant on set times. • Bed environment must be assessed using Environment Risk Assessment/ Risk Management proforma (ward team) The patient must not be placed in 1-2 bedded side rooms. Patients in this category should, where possible, be placed in easy view of the nursing station. Placement on ward must afford maximum observation (bed management/ ward team) • The patient must not be allowed to leave the ward unescorted. The patient must be accompanied by a nurse or a relative/career. This must be clearly recorded in the patient's care plan • Comprehensive documentation of all observation must be recorded. • If the patient attempts to leave the ward this must be responded to as an emergency. • The nurse in charge must inform – • ➢ Trust Security – using 2222 the Trust Security emergency response procedure • ➢ Trust Site Manager - Ext 6537 • Ward nursing and medical staff should take reasonable steps to detain the patient, maintaining the safety of staff, the patient and of other patients until the arrival of the Security team and the Site Manager on the ward and action taken in accordance with the Trust Missing Patient Policy. **Patient to be referred to and reviewed within 36 hours by the Mental Health Liaison Practitioner or Psychiatrist**

Date	Time	Comments

Patient Environment Risk Assessment for a patient at risk of self harm / harm to others

LOW Risk These patients having been assessed by the Mental Health Liaison Practitioner / duty psychiatrist as low risk requiring a supportive form of observation called low supervision. Patients considered to be assessed at 'low risk' are not in need of any special observation/supervision. Current inpatient deemed to be at risk of DSH following deterioration in clinical condition **Possible mental health signs of risk** • Mental health problems may be present, but person has no thoughts or plans regarding harm to self or others. • Patient may have already engaged in impulsive self-harming behaviour, but now regrets actions and has no plans or thoughts relating to further SH. • Patient is confident about maintaining their own safety and relative/significant others are prepared to provide support on discharge. • No evidence of immediate or short-term physical vulnerability or risk.	• Patients in this category should, where possible, be placed in easy view of the nursing station, and checked by designated staff member hourly when awake and every 30 minutes during the night. Face to face contact is required by a member of the ward team. • Bed environment must be assessed using Environment Risk Assessment/ Risk Management proforma (ward team) • The allocated nurse must document each patient contact. • The allocated nurse must report any concerns she/he has for the patients' safety or change in their state to the nurse in charge, as per care plan, who will assess the patient and, if necessary, request psychiatric or medical assessment. • The patient must be asked to inform the allocated nurse if she/he wishes to leave the ward. The allocated nurse must escalate to the nurse in charge where the patient wishes to go and the reason why the patient wished to leave. The nurse in charge must agree whether the patient can leave the ward unsupervised and a time for the patient to return must be agreed before the patient is allowed to leave the ward. • If the patient fails to return to the ward at the agreed time the Site Manager and Security must be notified immediately and action taken in accordance with the Trust Missing Patient Policy.

Date	Time	Comments

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Appendix 2

Emergency Department DSH Risk Assessment Proforma

A&E No:

Patient's name:

Date:

Time of examination:

Examining doctor:

Signature/Grade/Specialty ……..

History of DSH:

Method:
Drugs ☐ Cuts ☐ Gas ☐ Hanging ☐ Jump ☐

Other ☐ Describe ……

Time of DSH:…… Estimate patient's weight: ……..

No. of tablets taken: ……
Name of Drug(s) ……..

Patient's reason for DSH: (brief)

……..

Outcome:
Admitted to: MAU: ☐
Hellesdon: ☐
Referred CPN/Access ☐
Discharged – no follow-up ☐
Discharge to GP ☐
Self-discharged ☐
Advice sheet given?
Please specify ……

Modified SAD Score:	Score
Sex male	1
Age < 19yrs or > 45yrs	1
Depression or hopelessness	2
Previous suicide attempts or psychiatric care	1
Excessive alcohol or drug use	1
Rational thinking loss (psychotic or organic illness)	2
Separated, widowed or divorced	1
Organised or serious attempt	2
No social support	1
Stated future intent (determined to repeat or ambivalent)	2

Score =

Score < 6 LOW RISK -may be safe to discharge (depending on circums)
Score 6-8 MEDIUM RISK- likely to require psychiatric consultation
Score > 8 HIGH RISK – likely to require hospital admission & referral to psychiatric team

Psychiatric Assessment (filled in by S/N/Dr)

Appearance
(Immediate impression)

Behaviour
(External observable action)

Communication
(Speech pattern/body language/eye contact)

Disability
(previous psychiatric history/current medication/current CPN)

Environment
(Where they live/who with/care + support)

Quick Look Test:
Does the patient look: Well (comfortable) □
Ill (distressed/uncomfortable) □
Critical □

Does the method of harm require immediate intervention? □

Quick Look Test:
The following help list is designed as an adjunct to triage and could be useful in assessing urgency of intervention or facilitate an accurate decision/direction if patients decide to leave prior to being seen by the A&E doctor.

It is <u>not</u> a formal psychiatric assessment, nor replaces accurate and thorough assessment by the SHO.

We anticipate using the following A, B, C model:

Appearance – Your first impression. Do they appear:
- Neglected
- Withdrawn
- Excitable
- Dress – dishevelled or inappropriate

Behaviour – Do they appear:
- Retarded/slow
- Aggressive
- Agitated
- Exhibitionist in nature
- Bizarre

Communication – Is their speech:
- Disjointed
- Appropriate
- Does it make sense
- Quick or slow
- Is there an element of agitation, aggression or expression of suicidal thought
- Is there poverty of speech/unwillingness to communicate or muteness
- Is there flight of ideas, pressure of speech, neologisms or word salads

Disorder – Obvious psychiatric disorder
- Psychosis
- Overt depression
- Strong past medical history
- Expressing suicidal thoughts or harm to self or others

Environment/explanation – What is the 'Trigger Presentation'?
- In their words what has happened and why
- Recent discharge from hospital
- Living alone
- Are they disinhibited with alcohol
- Support network

- Recent events e.g. bereavement, divorce etc.

Care Guidance for : PATIENT AT RISK OF DELIBERATE SELF HARM - HIGH RISK **Appendix 3**

CARE DOMAIN: Care Guidance for : PATIENT AT RISK OF DELIBERATE SELF HARM - HIGH RISK	
AIM	**GUIDANCE FOR EVALUATION**
Prompt identification and care of patients who are at high risk of deliberate self harm.	**1. Use "evaluation of care" column to either:** **a. Tick "no issues"** **b. Write brief details of issue & the care required & given as a result of your evaluation** **2. If significant care is given or changes in status, also write in PCR and document in column 'See PCR'.**

NURSING INTERVENTION

Refer to the Trust Policy and Procedure for the Risk assessment and management of an adult patient who is at risk of deliberate self harm. (2012)

The senior Nurse/Midwife responsible for the care of the patient must complete a patient specific risk assessment which must be clearly documented in the patient nursing / midwifery records. The guidance detailed below must be referred to when undertaking risk assessment.

- Ensure placement on ward that affords maximum observation (bed management &ward team).
- Ensure an assessment of the bed environment has been undertaken using the Patient Environment Risk Assessment for a patient at risk of self harm / harm to others
- Ensure close supervision is provided on one to one basis - a Registered Mental Health Nurse (RMN) should be requested. In the situation that a RMN cannot be secured, then the next level is a RN. Patient Environment Risk Assessment for a patient at risk of self harm / harm to others Patient must not be left alone in any circumstance.
- All ward staff must be aware of the High Risk patient and which of the two levels of observation 'within eye sight' or 'within arms length' is most appropriate for the patient. This must be agreed and stated in the records by the assessing clinician.
- Trust Self Harm Care Plan and risk management plan must be followed with comprehensive documentation/ observation recorded in the patient records.
- The patient must not be allowed to leave the ward or to self discharge until full review by medical team and psychiatrist/ Mental Health Liaison Team.
- If the patient attempts to leave the ward or is found to be missing during routine checks or rounding this must be responded to as an emergency and action taken in accordance with the Trust's Missing Person Policy.
  The nurse in charge must inform :
  - Trust Security – using 2222 the Trust Security emergency response procedure
  - Trust Site Manager – Ext 6537
- Ward nursing and medical staff should take reasonable steps to detain the patient, maintaining the safety of staff, the patient and of other patients until the arrival of the Security team and the Site Manager on the ward.

The Patient must be referred to and reviewed by the Mental Health Team / Psychiatrist within 24 hours of admission

Care Guidance for : PATIENT AT RISK OF DELIBERATE SELF HARM - MEDIUM RISK Appendix 4

CARE DOMAIN: Care Guidance for : PATIENT AT RISK OF DELIBERATE SELF HARM –MEDIUM RISK	
AIM	**GUIDANCE FOR EVALUATION**
Prompt identification and care of patients who are at medium high risk of deliberate self harm.	**3. Use "evaluation of care" column to either:** **a. Tick "no issues"** **b. Write brief details of issue & the care required & given as a result of your evaluation** **4. If significant care is given or changes in status, also write in PCR and document in column 'See PCR'.**
NURSING INTERVENTION	

Refer to the Trust Policy and Procedure for the Risk Assessment and Management of an adult patient who is at risk of deliberate self harm. (2012)

The senior Nurse/Midwife responsible for the care of the patient must complete a patient specific risk assessment which must be clearly documented in the patient nursing / midwifery records. The guidance detailed below must be referred to when undertaking risk assessment. Each risk identified should be rated individually.

- Ensure close observation and supervision by ward staff (30 minute or hourly face to face checks both day and night).
- The patient must be observed by either a RN or a HCA who has been trained in observations of self- harming patients.
- All ward staff must be aware of the Medium Risk patient and that intermittent observation as outlined above must be followed.
- Ensure that the bed environment has been assessed using Patient Environment Risk Assessment for a patient at risk of self harm / harm to others.
- The patient must not be placed in 1-2 bedded side rooms. Patients in this category should, where possible, be placed in easy view of the nursing station. Placement on ward must afford maximum observation (bed management/ ward team)
- The patient must not be allowed to leave the ward unescorted. The patient must be accompanied by a nurse or a relative/career. This must be clearly recorded in the patient's care plan.
- Comprehensive documentation of all observations must be recorded.
- If the patient attempts to leave the ward or is found to be missing from the ward during routine observation /rounding this must be responded to as an emergency and action taken in accordance with the Trust's Missing Person Policy.
  The nurse in charge must inform –
  - Trust Security – using 2222 the Trust Security emergency response procedure
  - Trust Site Manager - Ext 6537
- Ward nursing and medical staff should take reasonable steps to detain the patient, maintaining the safety of staff, the patient and of other patients until the arrival of the Security team and the Site Manager on the ward and action taken in accordance with the Trust Missing Patient Policy.

Patient to be reviewed within 36 hours by the Mental Health Liaison Practitioner or

psychiatrist

Care Guidance for : PATIENT AT RISK OF DELIBERATE SELF HARM - LOW RISK **Appendix 5**

CARE DOMAIN: Care Guidance for : PATIENT AT RISK OF DELIBERATE SELF HARM – LOW RISK	
AIM	**GUIDANCE FOR EVALUATION**
Prompt identification and care of patients who are at medium high risk of deliberate self harm.	**5. Use "evaluation of care" column to either:** **a. Tick "no issues"** **b. Write brief details of issue & the care required & given as a result of your evaluation** **6. If significant care is given or changes in status, also write in PCR and document in column 'See PCR'.**

NURSING INTERVENTION

Refer to the Trust Policy and Procedure for the Risk Assessment and Management of an adult patient who is at risk of deliberate self harm. (2012)

The senior Nurse/Midwife responsible for the care of the patient must complete a patient specific risk assessment which must be clearly documented in the patient nursing / midwifery records. The guidance detailed below must be referred to when undertaking risk assessment. Each risk identified should be rated individually.

- Patients who are assessed as at low risk should, where possible, be placed in easy view of the nursing station, and checked by a designated staff member hourly when awake and during the night. Face to face contact between the patient and the member of staff is required.

- The bed environment must be assessed using Patient Environment Risk Assessment for a patient at risk of self harm / harm to others.

- The designated staff member must document each patient contact in the patient record.

- The designated staff member must report any concerns she/he has for the patients' safety or change in their mental state to the nurse in charge, as per care plan, who will assess the patient and, if necessary, request further psychiatric or medical assessment.

- The patient must be asked to inform their designated member of staff when she/he wishes to leave the ward. The designated member of staff must escalate to the nurse in charge where the patient wishes to go and the reason why the patient wished to leave. The nurse in charge must agree whether the patient can leave the ward unsupervised and a time for the patient to return must be agreed before the patient is allowed to leave the ward.

- If a patient is found to be "missing" during routine checks/ intentional rounding the Security team (2222) and the Site Manager (6537) must be notified and action taken in accordance with the Trust Missing Patient Policy.

Appendix 6

Levels of observation for patient who are vulnerable / at risk:

Level 1 – Standard Observation
The location of the patient should be known to staff at all times, but they are not necessarily within sight. At least twice per shift, the patient's allocated Registered Nurse will communicate with the patient and an entry of the outcome of any assessment will be made in the patient's nursing notes or medical records. At the beginning and end of every nursing shift the whereabouts and general condition of all patients should be part of the handover.

Level 2 - Intermittent Observation

This is an increased level of observation for patients, who after assessment, may be deemed to be a potential risk of falls, may have dementia or disturbed and/or violent behaviour or be at low risk of deliberate self harm This may include those who have a history of previous risk but are in the process of recovery. Patients assessed to be within this category should be placed on a care plan which should clearly indicate; the intervals at which observations should be carried out, (15, 30 minutes etc). Exact times should be specified. High risk activities and times of the day should also be planned for, example going to the toilet when at risk of falls, the needs of patients at night when lighting is subdued and staff numbers are decreased e.g. nights or breaks.

The need for an assessment by the Registered Nurse of the patient on each shift and a summary of the patient's behaviour, physical and mental state should be recorded in the nursing records/patients notes at the end of each shift. All staff on that shift and those who are responsible for intermittent observation should be consulted prior to taking over and handing over care to the next shift.

Level 3 - Within Eyesight Observation

Following a risk assessment, these patients are at **'high risk'** for example with a history of falls, advanced dementia, assessed at medium risk of deliberate self harm /liable to make an attempt to harm themselves or others at any time. They may be "at risk" of absconding or are considered to have an unstable physical or mental condition which may deteriorate and requires continuous assessment. They should be within eyesight and accessible at all times, day and night. These patients should have a care plan for special observations contained within their notes.
Any equipment or instruments deemed harmful that could be used should be removed if necessary. This may warrant searching of the patient and their belongings. This should be done with consideration given to the legal rights of the patient and conducted in a sensitive manner.
The care plan must state if the patient does not require observation whilst using the toilet or bathroom, or attending another department for tests or investigations. A regular summary of the patient's condition, care and treatment must be entered on the special observation care plan. This must include changes in mental state, physical, psychological, and social behavior, and significant events. Positive engagement with the patient is essential.

It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place. If there are concerns that the patient is being deprived of their liberty then appropriate action should be taken in accordance with Trust MCA and DOL policy.

Level 4 - Within Arm's Length Observation

This is the highest level of observation for patients liable to suicide attempts or at high risk of harm to themselves or others. They may be at "**high-risk**" of falls due to confusion or have an unstable physical condition which may deteriorate and requires continuous assessment. All patients in this category require at least 1:1 nursing.

They should be supervised with close proximity, with due regard for safety, privacy, dignity, gender and environmental dangers which should be assessed and incorporated into their care plan.
It may be necessary on rare occasions to use more than one member of staff and or specialist support i.e. RMN or Learning disabilities nurse. A regular summary of the patient's condition, care and treatment must be entered into the care plan. This must include changes in mental state, physical, psychological and social behavior, and significant events. Positive engagement with the patient is essential.

It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place and take appropriate action.

Assessment and Management of Patients with a history of self-harm at the James Paget University Hospitals NHS Foundation Trust

Dr Donna Wade – Consultant in Emergency Medicine, 31 March 2015

Initial assessment

The majority of patients with a history of self-harm attend A&E via ambulance. The paramedic transporting these patients to A&E will hand the patient over to the shift coordinator in the majors area of the department.

Patients who are medically unwell will then be transferred to a majors or resuscitation room (resus) cubicle, where a member of nursing staff will check their observations, and based on the history from the ambulance crew on the patient decide on the urgency with which they need to be seen by a doctor.

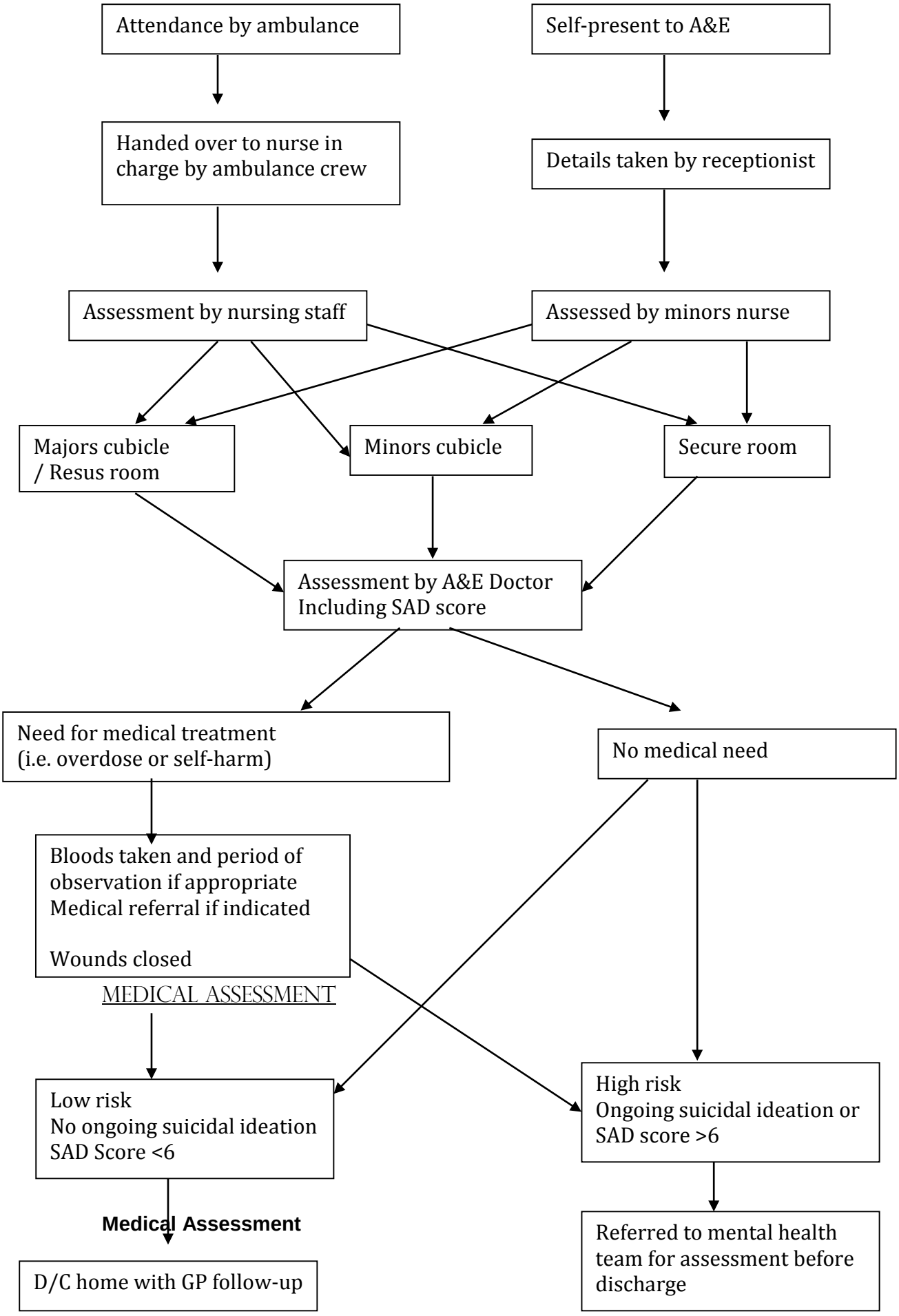
Patients who are medically stable, but who have self-harmed, may be transferred to a cubicle in minors, where they will again be assessed by a member of nursing staff to have the urgency of medical assessment determined.

If a patient is thought to be at high risk of further self-harm while in A&E, or has altered behaviour due to alcohol, drugs or mental illness, then they will usually be transferred to our secure room, where a member of security or portering staff will be called to wait with the patient in order to ensure their safety. Nursing staff will attempt to check the patient's observations, if the patient consents to this, while maintaining their own personal safety.

Patients self-presenting to A&E with a history of self-harm are identified by nursing staff working in the minors area by the details on the edis (emergency department information service) screen, which lists all patients in the ED, together with their presenting complaint. These patients should be prioritised to be brought into the minors area and assessed. If a 'see and greet' nurse is working, then they may be taken into the assessment room in the waiting room and have an initial assessment performed in there.

Patients who have self-harmed should not generally be asked to wait in the waiting room, due to the risk of them absconding. However, if patients self-present to A&E then they there may be a delay before a cubicle becomes available for them, and they may therefore be requested to wait in the waiting room for a brief period of time.

Flowchart for mental health patients presenting to A&E



Patients who have self-harmed will then be seen by a member of medical staff (or if the self-harm is from lacerations alone, then they may be seen by an ENP (emergency nurse practitioner)). A full history and examination will then be taken, including a history of the nature of the self-harm; the timing of this, the reasons behind it; the extent and duration of suicidal ideation; whether the patient told anyone at the time of the episode or not; and how they came to be in A&E. A physical description of the patient should also be recorded, in case they abscond from the ED. An aide-memoire on what information should be recorded as per nice guidelines is recorded on the sad score assessment sheets (see appendix 1), which are prominently displayed in both the minors and majors area of the ED, and are also available for clinicians to complete directly. All information is entered onto the EDIS system.

A previous psychiatric history will also be taken, to include previous episodes of self-harm, known mental health diagnoses, current psychiatric care, and current medication, as well as a general medical history, drug history and social history. These form the basis of the modified sad score, which is used to assess the risk of further self-harm events.

A physical examination will then be performed according to the nature of the self-harm, and initial blood tests and treatment performed.

If the self-harm has been by lacerations only, then wounds will be cleaned and closed. If self-harm involved ingestion of medication or other substances, then treatment will often involve blood tests four hours after ingestion of these, and a period of observation. Toxbase, the national poisons unit database is usually consulted in order to guide specific management of different ingested substances.

The majority of patients who have taken overdoses will be managed in A&E. The exception to this is patients who have taken medication such as SSRIs, or controlled release drugs, which require a prolonged period of cardiac monitoring. These patients are generally referred to EADU for admission. The other exception is patients who have a significantly reduced GCS after their overdose, which cannot be reversed with naloxone. These patients are referred to the ITU team for consideration of intubation and ventilation.

<u>Referral to the CRHT</u>

Once a patient is medically fit for discharge (which may occur in A&E, EADU or on one of the medical wards after discharge from ITU), the clinician seeing the patient makes an assessment of the risk of further self-harm, based on the history, the presence of on-going suicidal ideation and the sad score.

Patients judged to be at low risk of further significant self-harm, for example those who have taken an impulsive overdose and now regret the attempt, or those who have a history of self-harm with blades, with no suicidal intent, may be discharged home with advice to follow-up with their general practitioner.

Patients judged to be at risk of further suicidal attempts are referred to the CRHT by telephone referral. The CRHT should then in theory come to assess the patient within 4 hours of the referral time. In practice this often takes considerably longer, especially overnight due to pressures on their staffing levels.

Patients leaving the ED without being seen, or before full assessment and treatment has occurred

We have recently updated our self-discharge form, following a serious untoward incident, which is going to inquest later this year. Any patient who wishes to self-discharge from the ED will now have a capacity assessment performed by a member of medical or nursing staff, and only be allowed to leave the ED if they are both deemed to have capacity and to not be at significant risk of further self-harm. The self-discharge form also contains information about the techniques that have been used to try to persuade the patient to remain for assessment and treatment, and a section to be signed by the patient detailed their diagnosis, the proposed treatment, and the risks of leaving without treatment.

If a patient leaves the ED without being fully assessed by a member of nursing or medical staff, and in whom the suicidal risk cannot be adequately assessed, then staff will initially look for the patient in the area around the ED, including the car park, and will notify security staff who can both look for the patient directly and check cctv cameras. Ed staff will also attempt to contact the patient directly using any available telephone numbers. If we are unable to find the patient, or to persuade them to return to the ED, then the police are contacted to perform a welfare check, and to return the patient to the ED if indicated.

Audits on management of self-harm patients in A&E

Audits undertaken on this topic can be divided into three groups:

1) Management of patients in the ED against CEM guidelines.

2) Management of patients in the ED against nice guidelines

3) Audits on time for mental health patients to be assessed by CRHT

1) CEM mental health audit 2014 (Appendix 2)

The College of Emergency Medicine mental health audit was performed looking at notes of 50 patients presenting to the ED in January and February 2014 with self-harm, as part of a national audit into the management of mental health patients in EDs against CEM standards for mental health, as detailed below:

<u>CEM Standards for Mental Health</u>

1) Patients who have self-harmed should have a risk assessment in the ED

2) Previous mental health issues should be documented in the patient's clinical record

3) A Mental State Examination (MSE) should be recorded in the patient's clinical record

4) The provisional diagnosis should be documented in the patient's clinical record

5) Details of any referral or follow-up arrangements should be documented in the patient's clinical record

6) From the time of referral, a member of the mental health team will see the patient within 1 hour

7) An appropriate facility is available for the assessment of mental health patients in the ED

In the sample looked at, all of the patients had taken overdoses. The formal report on this has not yet been released by CEM, but the raw data is attached in appendix 2, and is summarised below, according to the key factors in the CEM standards.

1) A risk assessment was taken in 40 /50 patients, and in an additional 1 a reason for not recording was given.

2) A history of previous mental health issues was taken in 46/50 patients.

3) A mental state was only recorded in 23 patients, but as the vast majority were referred to the mental health team, this seems reasonable.

4) Provisional diagnosis was recorded in all 50 patients.

5) Details of follow-up arrangements or referrals were documented in 40/50 patients, and were not applicable in 2.

6) 48/50 patients were referred to the CRHT in 48/50 cases. Of these, 2 were admitted to an inpatient unit, 2 absconded, and the remaining 44 patients were discharged home.

Of these, 32/50 patients waited more than 4 hours after arrival to be seen by a member of the mental health team. In some cases this may have been due to a delay in A&E staff being able to declare the patient medically fit, but this does represent a prolonged wait in the ED for this patient group. Only 3/50 patients were seen within 1 hour of arrival, but this does not mean within 1 hour of referral, as unfortunately this data was not captured by this audit. This does however suggest a significant failure to meet the 1 hour target set by the CEM, although current commissioning arrangements are for patients to be seen within 4 hours of referral.

7) An appropriate facility for the assessment of mental health patients in the ED is available, and has been fully fitted out with two access doors, a panic bar, and no internal ligature points as part of the recent ED refit. However, this room is also used for general medical and surgical patients as pressures on space in the ED mean that it is not realistic , to keep this room empty while other patients are facing a prolonged wait on ambulance trolleys. Patients who have self-harmed may also require closer monitoring than is possible in this room. It was not possible during the audit to determine which patients had been seen in the dedicated secure room and which in other areas of the ED.

2) Audits against NICE Guidleines

Three audits have been performed on this in sequential years, and can be found in Appendixes 3 and 4.

The SAD score / management of self-harm patients sheet has been rewritten after the first two audits in order to improve documentation and appropriate referrals of mental health patients to CRHT. Additional teaching for medical staff has also been put in place to improve adherence with guidelines, and there has been evidence of improvement with adherence to these guidelines.

Results are summarised below:

1) Administration of charcoal within 1 hour of overdose.

This was administered in the very few patients arriving in the ED within the time-frame in all three audits (1 or 2 patients a year only)

2a) Recording of capacity and willingness to accept treatment at Triage

This increased from 8% in 2012 to 70% in 2013, and dipped slightly to 60% in 2013. This is being addressed by teaching, but the recent teaching programme in the Trust on capacity and consent to treatment should help this.

2b) Recording of need for physical care.

This increased from 38% in 2012 to 76% in 2013 and 88% in 2014.

2c) Recording of level of distress

This again increased from 22% in 2012 to 64% in 2013 and 74% in 2014, reflecting the on-going teaching programme.

3) Documentation of SAD persons score

This has remained fairly static at 76% in 2012, and 72% in 2014. Education about this is on-going.

4) Referral of patients with a SAD score >6 or on-going suicidal intent

Reassuringly this has been 100% in all three audits.

5) Assessment of social and psychosocial needs

This has again remained fairly static at 82% in 2012 and 76% in 2014.

6) Audits on time for patients to be assessed by CRHT

Four audits have been completed on this, enabling a comparison as detailed below"

Time from referral to CRHT assessment	2009	2010	2012	2015
< 1 hour	23%	8%	21%	6%
1-4 hours	85%	72%	68%	71%
> 4 hours	4%	20%	11%	23%

Prolonged delays in assessment often result in distress to patients, and can also create a management problem within the ED. Mental health patients can present a management problem, and often require 1:1 observations by a member of security staff, or high levels of input from nursing staff in order to dissuade them from leaving the ED before CRHT assessment.

Appendix 9 contains four case studies of mental health patient who had prolonged waits in the ED for assessment or transfer to an inpatient bed.

Total numbers of ED attendances of patients with mental health patients are also increasing:

Year	Mental health attendances over 1 month
2011	96
2012	107
2013	127
2014	121
2015	134

Appendix 8 demonstrates the numbers and diagnoses of mental health patients attending the ED, which demonstrates that an average of 50 patients a month attend with a history of actual self-harm. A number of these patients attend with recurrent attempts at self-harm of poisoning.

In addition and average of 11 patients a month present to the ED with a risk of suicide.

APPENDICES

1) Modified SAD Score and assessment sheet for self-harm patients in the ED
2) CEM Management of Mental Health Patients Audit 2015
3) NICE self harm audit 2012
4) NICE self-harm audit 2014
5) 2010, 2012 AND 2015 audits of time from referral to CRHT review
6) 2009 audit on psychiatric attendances to ED and time to CRHT review
7) 2014 Audit of referrals to CRHT from JPH A&E
8) Audit of numbers and diagnoses of mental health patients attending ED
9) Case studies of patients with prolonged waits in the ED
10) Trust Self-discharge form
11) Audit of patients self-discharging from the ED

APPENDIX 1

ASSESSMENT OF PATIENTS FOLLOWING AN EPISODE OF DELIBERATE SELF-HARM

JPUH MODIFIED SAD PERSONS SCORE

S - Male Sex	1
A – Age 35 - 49	1
D - Depression or Hopelessness	2
P - Previous attempts or Psychiatric care	1
E - Excess Etoh or drug use	1
R - Rational thinking loss	2
S - Single, widowed, divorced, abusive relationship	1
O - Organised or serious attempt	2
N - No social support or unemployed	1
S - Stated future intent or ambivalent	2

Total Score :

Refer to the mental health team if :

Total score 6 or more,

OR

High risk attempt (planned or concealed attempt, final acts, delayed presentation, violent mechanism)

OR

On-going suicidal intent.

Further actions

1) Record time and nature of attempt and precipitating factors on EDIS

2) Record brief physical description of patient

3) Does the patient have the capacity to make decision about their care?

4) Are they willing to stay for further assessment / medical treatment? (If not d/w senior A&E doctor before allowing to leave ED)

5) Do they need any physical care (including activated charcoal within 1 hour of overdose) as a result of their episode of self-harm?

6) Do they appear distressed at present? If yes, consider early medical assessment +/- medication such as lorazepam.

Please record all of the above on EDIS. **Do not allow the patient to leave the ED without discussion with a senior doctor.**

APPENDIX 2

CEM MENTAL HEALTH AUDIT (2014/2015) - SUMMARY FOR YOUR DEPARTMENT

No. of cases audited in this ED: 50
Start date: 01/01/2014
End date: 08/08/2014

	Question	Answer	Total number of patients
Q3	Was the type of self-harm recorded?	Self-injury	0
		Self-poisoning	50
		Not recorded	0
Q4	Was a risk assessment taken and recorded in the patient's clinical record?	Yes	40
		No – reason why not recorded	1
		No - patient left before risk assessment	0
		Not recorded	9
	If YES, was the patient specifically asked about: suicidal intent and acts; safeguarding concerns; assessing risk of repetition; assessing risk of potential harm to others	Yes - all	1
		Partially – some of these	38
		No – none of these	1
		Not recorded	0
Q5	Was a history of patient's previous mental health issues taken and recorded in the patient's clinical record?	Yes	46
		No - reason why not recorded	0
		Patient left before history taken	1
		Not recorded	3
Q6	Was a mental state examination taken recorded in the patient's clinical record?	Yes	23
		No - reason why not recorded	0
		No - Patient left before MSE	1
		Not recorded	26
Q7a	Was the patient asked about their alcohol & illicit substance consumption within the last 24 hours and the answers documented in the patient's clinical record?	Yes	36
		No - reason why not recorded	9
		No - Patient left before consumption assessment	1
		Not recorded	4
Q7b	Was the patient assessed for their level of alcohol &/or illicit substance dependency and the answers documented in the patient's clinical record?	Yes	27
		No - reason why not recorded	9
		No - Patient left before dependency assessment	1
		Not recorded	13
Q8	Was a provisional diagnosis documented and recorded in the patient's clinical record?	Yes	50
		No - prov. diagnosis undecided	0
		No - Patient left before diagnosis reached	0
		Not recorded	0
Q9	Was the patient assessed by a mental health practitioner (MHP) from your organisation's specified acute psychiatric service?	Yes	48
		No – MHP unavailable	0
		No - Patient left before assessment by MHP	2

		Not recorded	0
	If YES, how quickly was patient seen by MHP?	≤ 1 hour of arrival	3
		≤ 4 hours of arrival	12
		> 4 hours of arrival	32
	If YES, where was the patient assessed by the mental health practitioner?	Dedicated assessment room	1
		Resus area	1
		Majors area	4
		Minors area	5
		Other	21
		Not recorded	16
Q11	Where was the patient discharged to from the ED?	Place of normal residence	46
		Voluntary admission to mental health facility	1
		Involuntary admission to mental health facility	1
		Patient absconded	2
		Not recorded	0
Q12	Were details of any referral or follow-up arrangements documented in the patient's clinical record?	Yes	40
		Not applicable	8
		Not recorded	2
Q13	Does your organisation have a Liaison Psychiatry service?	Yes	2
		Under development	0
		No	0
Q14	Does your ED have a dedicated assessment room for mental health patients?	Yes	2
		No	0
	If YES, does the room meet the standards set out by the Psychiatric Liaison Accreditation Network?	ALL met	0
		Half or more met	1
		Less than half met	0
		NONE met	0

APPENDIX 3

NICE Self-Harm Audit 2012

Introduction

The NICE Self-Harm Guidelines 2011 (CG16), sest out guidelines for the management of patients who have self-harmed in both primary and secondary care.

The key recommendations include:

1) Activated Charcoal

This should be offered to patients who attend the ED within 1 hour of an overdose of relevant substances, or up to 2 hours if clinically appropriate.

2) Triage in the Emergency Department

Patients should be offered a preliminary psychosocial assessment at triage (or initial assessment) following an act of self-harm. This should include:

a) Assessment of Mental Capacity and willingness to accept treatment

b) Level of distress and evidence of presence of mental illness

c) Need for physical care

3) Further Psychosocial Assessment

Every patient who has self-harmed should have a comprehensive assessment of needs and risks, to include:

a) Social situation

b) Personal relationships

c) Recent life events

d) Psychiatric history

e) Mental State Examination

f) Motivation for act

g) Enduring psychological characteristics associated with self-harm

4) Risk assessment

All people who have self-harmed should be assessed for risk. This should be clearly documented in their notes. Referral for further assessment should be based on the risk assessment.

Method of audit

To assess compliance with the NICE guidelines, 50 consecutive sets of EDIS notes, from ED patients attending with a diagnosis of 'Psychiatric - overdose' were reviewed, starting from 01/08/2012 and continuing for up to 6 months, or until 50 sets of notes were found.

All patients over the age of 16 were included. Patients who were unconscious and therefore unable to undergo a full psychological assessment were excluded from the audit. However, patients who were drowsy and were able to provide some history were included.

The following data was recorded for each patient:

1) Was activated charcoal offered within 1 hour of poisoning, or 2 hours if clinically indicated?

2) Is there documented evidence that the triage assessment includes:

a) Capacity and willingness to accept treatment

b) Need for physical care

c) Level of distress

3) Does the patient have a SAD PERSONS score fully assessed and documented?

4) Was the patient referred to the mental health team if indicated by SAD score > 6 or ongoing psychiatric risk?

5) Was there an assessment of social and psychological needs made?

Results

Fifty sets of EDIS notes were audited, from 01/08/2012 to 04/10/2012.

<u>Question 1 -Was activated charcoal offered within 1 hour of poisoning, or 2 hours if clinically indicated?</u>

Yes in 2 patients, not applicable in 48. This reflects the fact that most patients arrive in the ED several hours after their overdoses, when activated charcoal is not indicated. In the two cases when it was indicated, it was given. Compliance rate for appropriate administration of charcoal was therefore 100%.

<u>Question 2-</u> <u>Is there documented evidence that the triage assessment includes:</u>

a) Capacity and willingness to accept treatment

Recorded in 4 patients, not recorded in 46. Compliance rate 8%.

This reflects the fact that patients in JPH ED are not formally triaged in the minors area, and the initial nursing assessment in the majors area generally consists of recording of observations only, due to pressure on nursing staff.

In the vast majority of cases, the initial assessment recorded was the doctor who saw the patient, and a willingness to wait to be assess would indicate a willingness to accept treatment.

b) Need for physical care

Recorded in 19 patients, not recorded in 31.

Compliance rate 38%

c) Level of distress

Recorded in 11 - Not in 39

Compliance rate 22 %

Question 3 - Does the patient have a SAD PERSONS score fully assessed and documented?

Recorded in 35 patients, not recorded in 11, unable to record in 4 patients, as the patient was either too drowsy or was nunwilling to answer questions.

Compliance rate therefore 76%.

Question 4 - Was the patient referred to the mental health team if indicated by SAD score > 6 or ongoing psychiatric risk?

25 patients were referred; the others were not referred because they were not felt to be at high risk, or were being admitted under the medical team, as per protocol. No high risk patients were discharged from the ED.

Compliance rate for referral of appropriate patients was therefore 100%

Question 5 - Was there an assessment of social and psychological needs made?

While this was only fully documented in 7 patients, by definition all of the 35 patients who had a SAD score documented must have had this assessment made.

Therefore an assessment was made in 39 patients, with no assessment being possible in 2 patients. No assessment was documented at all in 9 patients, giving a compliance rate of 82%.

Discussion

The 100% compliance with offering activated charcoal to appropriate patients, and for referral of appropriate patients to the mental health team indicates that safe practice is currently occuring for this patient group.

The current short fall is in documentation, which needs to be improved, and in the full assessment of this patient group at ‘triage’ or by the first member of medical or nursing staff who sees them. The reasons for this short fall are multi-factorial:

The primary reason is a lack of a triage or assessment nurse in the minors area at the time of the audit. We are currently running a trial, with a ‘see and greet’ nurse present in the ED for

three days a week. This member of staff would be ideally placed to carry out these assessments, using a proforma. However, out of hours there are simply not enough members of nursing staff to carry out this task. Similarly in the majors area at busy times there are not enough members of nursing staff to carry out a full assessment of this type, nor is it likely in my opinion to significantly improve care or alter patterns of referral.

If full compliance with the guideline is felt to be necessary then the Trust would either have to invest in more nursing staff for the ED, or employ a mental health liason nurse, who could carry out this role.

Proposals for further action

The SAD score sheet, already used in the ED has been rewritten to include reminders re the recording of capacity, willingness to accept treatment, need for physical care, and level of distress.

I would propose a further audit in 6 months time to assess the impact of this change.

Donna Wade
A&E Consultant
3rd March 2013

APPENDIX 4

NICE Guidelines on the initial Management of Self Harm in the James Paget A+E Re-Audit. April 2014 – Dr Ben Cracknell

The NICE Self-Harm Guidelines 2011 (CG16), set out guidelines for the management of patients who have self-harmed in both primary and secondary care. The key recommendations include:

8) Activated Charcoal
This should be offered to patients who attend the ED within 1 hour of an overdose of relevant substances, or within 2 hours if felt to be clinically indicated, based on the substance ingested.

3) Triage in the Emergency Department
Patients should be offered a preliminary psychosocial assessment at triage (or initial assessment) following an act of self-harm. This should include:

c) Capacity and willingness to accept treatment
d) Need for physical care
e) Level of distress of the patient

4) Further Psychosocial Assessment
Every patient who has self-harmed should have a comprehensive assessment of needs and risks, to include:

a) Social situation
b) Personal Relationships
c) Recent Life Events
d) Psychiatric History
e) Mental State Examination
f) Motivation for act
g) Enduring psychological characteristics associated with self-harm

4) Risk assessment
All people who have self-harmed should be assessed for risk of further self-harm. This should be clearly documented in their notes. Referral for further assessment should be based on the risk assessment.

<u>Changes made after the 2013 audit</u>

The 2013 audit confirmed that a significant number of patients attending the A+E in the JPUH following a suicide attempt or self harm were discharged without recorded evidence of a satisfactory suicide risk assessment.

To rectify the issue, a number of changes were implemented after the audit was completed. The SAD score proforma was modified to include prompts for a risk assessment that fully conforms to the NICE guidelines. Awareness of the SAD score was raised by including it in the A+E junior's teaching sessions. Copies of the proforma were stored by the doctor's stations in A+E, and posters showing the guidelines were put up at the doctor's stations in A+E.

Method of Re-audit

To ensure there was no bias in the re-audit, the same methods were used as in the last audit carried out in August 2013. 50 consecutive sets of EDIS notes, from ED patients attending with a diagnosis of 'Psychiatric - overdose' were reviewed, starting from 20/04/2014 until 50 sets of notes were found.

All patients over the age of 16 were included. Patients who were unconscious and therefore unable to undergo a full psychological assessment were excluded from the audit. However, patients who were drowsy and were able to provide some history were included.

The following data was recorded for each patient:

2) Was activated charcoal offered within 1 hour of poisoning, or 2 hours if clinically indicated?

2) Is there documented evidence that the triage assessment included:

f) Capacity and willingness to accept treatment?
g) Need for physical care?
h) Level of distress of the patient?

3) Does the patient have a SAD PERSONS score (agreed method of risk assessment at JPH ED) fully assessed and documented?

4) Was the patient referred to the mental health team if indicated by SAD score > 6 or ongoing suicidal risk?

5) Was there a comprehensive assessment of social and psychological needs made, as per the NICE guidelines?

Results

Question 1 -Was activated charcoal offered within 1 hour of poisoning, or 2 hours if clinically indicated?

Yes in 1/50 patients, not applicable in 49/50.

The reasons for activated charcoal not being indicated varied, most were due to patients arriving more than 2 hours after their overdose. In a few cases this was due to activated charcoal was not being indicated (such as overdoses of insulin or an insufficient amount of a drug).

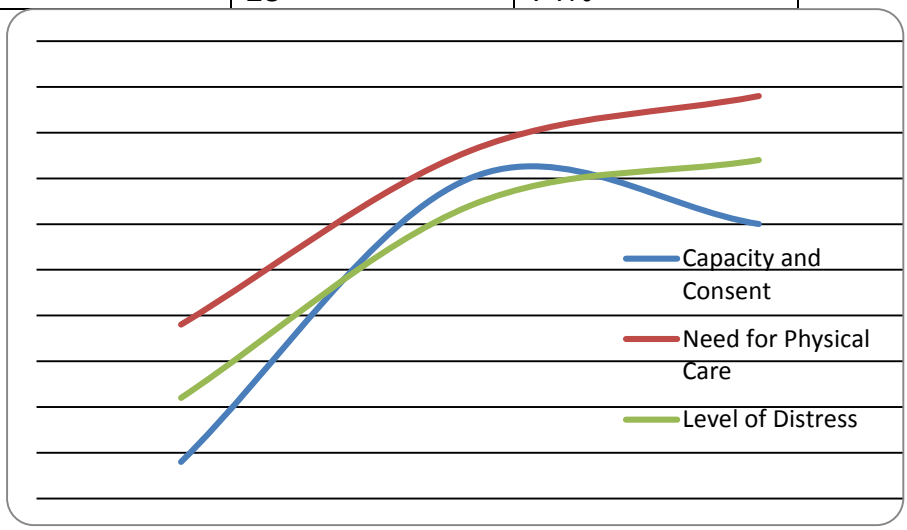
There were no cases where activated charcoal was indicated, and the patient arrived in time, but did not receive it. Compliance rate for appropriate administration of charcoal was therefore 100%.

There has remained a high standard of administering activated charcoal when it is clinically indicated. Compliance has remained 100% since 2012.

Question 2- Triage assessment

	Documented	Not Documented	Compliance Rate
Capacity and Consent	30	20	60%
Need for Physical Care	44	6	88%
Level of Distress	37	13	74%

In the minors area, a doctor usually performed the initial assessment. There is a see and greet nurse service, however this rarely resulted in a full entry including the three areas mentioned being recorded. The most common information documented by the see and greet nurse was basic observations (blood pressure etc).



Documentation of distress and physical care need have improved, however it appears recording of capacity and consent has gone down since 2013.

It could be argued that a patient attending the Emergency Department voluntarily is effectively consenting to assessment; a patient who has agreed to blood tests is consenting to investigations, and a patient who either allows intravenous medication (including fluids) to be administered or permits an assessment by the mental health team. However, the NICE guidelines state that both the patient's capacity and willingness to accept treatment must be formally documented. This was the most poorly documented in 2014.

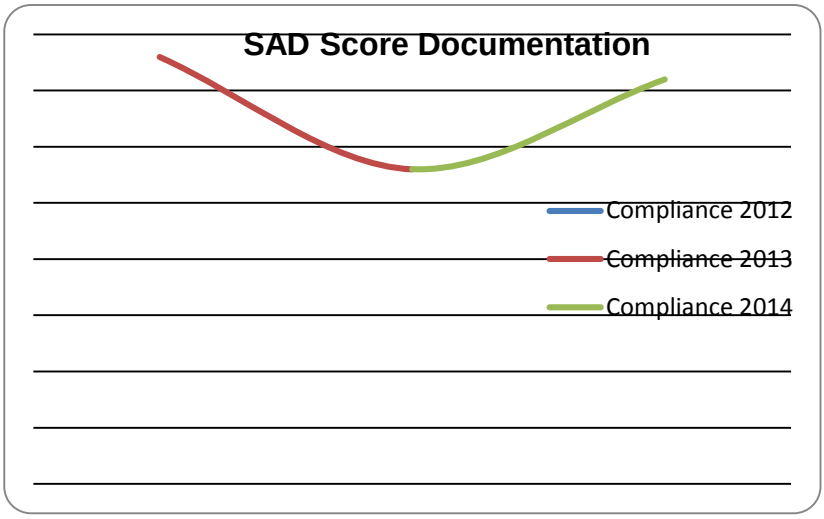
The need for physical care is generally reflected by the nursing observations, and whether the patient was well or required medical interventions due to abnormal physiological parameters. This was generally well documented in the medical notes.

The lack of documentation of distress would generally indicate its absence, but for the purpose of the guidelines, this needs to be documented. The documentation of this has been improving since 2012.

Question 3 - Does the patient have a SAD PERSONS score fully assessed and documented?

Yes in 36/50, No in 14/50. Compliance rate was therefore 72%.

Compliance with use of the SAD score has increased from the last audit, however has not reached the level that was recorded in 2012. This shows that changes made since the last audit made a difference, but there is still room for improvement.



The ideal situation would be every suicide risk patient having a SAD score documented as an easy reference point to look at to measure the patients suicide risk at that time and whether discharge was appropriate.

Question 4 - Was the patient referred to the mental health team if indicated by SAD score >6 or ongoing psychiatric risk?

All of the patients who had a SAD score documented >6 were referred, giving a compliance rate of 100% for this patient group. In addition, 6/14 patients were referred without a documented SAD score.

8 patients were not referred, and had no documented SAD score. This is risky from a medico-legal standpoint as there is no documented proof that these patients were safe to be discharged without further assessment. One of these patient's notes contained enough of a psychosocial risk assessment to comply with the NICE recommendations, however 7 did not contain sufficient information.

Compliance for this parameter must therefore be taken at 43/50 (86%), as there is no way of telling if the patients who were not referred and who had no SAD score recorded were high risk or not.

The compliance rate for this has increased since 2013, however there is insufficient data from 2012 to fully assess how many patients were not referred, and had an insufficient risk assessment documented in their notes, so no comment can be made on this year.

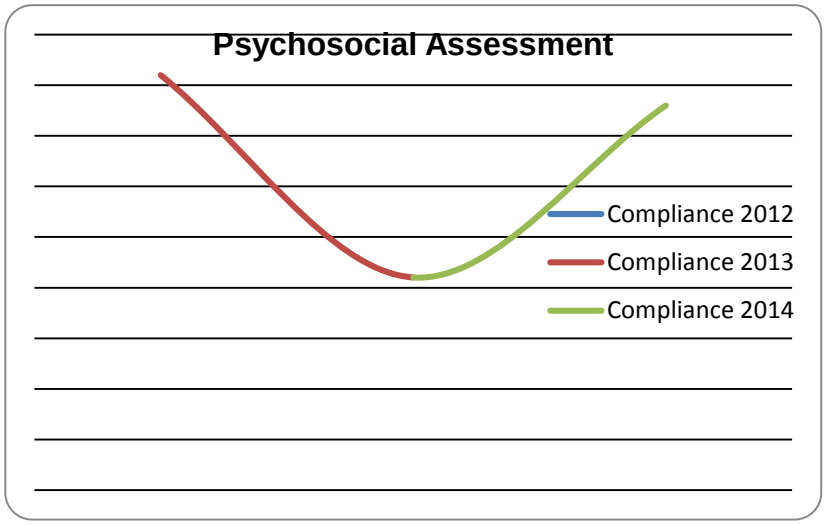
	Compliance 2012	Compliance 2013	Compliance 2014
Referral if high risk patient	Insufficient data	74%	86%

Question 5 - Was a comprehensive assessment of social and psychological needs made?

23/50 patients had a psychosocial assessment that met all the points set out in the NICE guidelines. 12/50 further patients had a partial psychosocial assessment that did not fully encapsulate all the areas, and the remaining 15/50 had no assessment documented.

Of these 27 patients that did not have sufficient assessment, 15 of these patients were referred to mental services anyway, so will have a full assessment documented by the mental health team, but the remaining 12 of these patients were not referred. Therefore, the compliance rate for an assessment of social and psychological needs was 38/50, 76%.

Compared to 2013 this is an increased rate of compliance. However the rate of compliance was higher in 2012. However, in 2012 the auditors allowed a SAD score to constitute a full psychosocial risk assessment. As a SAD score does not encompass all the points set out by NICE as a full psychosocial risk assessment, we took this to not represent a full psychosocial assessment. It is possible that the true compliance rate for full psychosocial assessments is not as high as was recorded in 2012.



Discussion

There are some practices audited that have remained at a high compliance rate, such as the administering of activated charcoal and referring patients with a SAD score of over 6 to the mental health team. The actual rate of administration of activated charcoal remains low, at only 1 patient, as few patients reach the ED within the indicated time frame. Administration of activated charcoal by ambulance crews would improve this, but is outside the remit of this audit.

Recording of triage information has improved once again; this information has been taken by doctors in most cases despite the presence of a triage nurse. We propose that See and Greet nurses in the minors area should be asked to document capacity, willingness to accept treatment, level of distress and need for physical care in order to drive up this standard. A SAD score poster will be put up in the see and treat nurse area and they will be informed of the score.

SAD score documentation has increased since the last audit, which indicates that the changes made in the last audit were successful in increasing awareness of the SAD score. More easily available SAD score sheets, posters in the A+E, including the score in the teaching sessions and encouraging the consultants to promote the SAD score has made a difference. There are still a significant number (28%) of patients who do not have a documented SAD score in the notes. It is proposed that the changes made in the last audit are continued. It is also proposed that the proformas whereabouts are made more obvious with a labelled storage shelf in A+E. Consultants will also be encouraged to promote the SAD score in A+E.

The psychosocial assessment of self-harm patients increased slightly since 2013. The number in 2013 was 21 and the number in 2014 was 23. The compliance rate is brought up significantly due to a number of patients being referred to the mental health team anyway (who in turn document a full psychosocial assessment in the notes). Reasons for the full history not being documented may include time pressures, poor history from the patient or lack of psychiatric experience in the clerking doctor. A SAD score is a useful tool in these situations, as it requires little patient co-operation, and is fast to carry out. Increasing awareness of the SAD score could improve this standard, as the pro-forma now includes information on the information required in a psychosocial history. This will be re-enforced in the junior doctor teaching programs and departmental inductions.

Failure to use a SAD score or document a full psychosocial history constitutes a clinical risk, as it may result in failure of an adequate assessment of future risk in patients who are subsequently discharged home. Ideally every patient who attends following self harm or a suicide attempt should have a full suicide risk assessment or at least a SAD score documented so further work to drive up the standards set out by NICE would be justified.

Conclusions

In order to ensure continued and improved compliance with the NICE Self-harm guidance, it is recommended that the above actions be taken, and that a repeat audit be taken in 6 -12 months time to assess the impact of these changes.

APPENDIX 5

Audit of time from referral to CRHT review August 2010

Date	Time of ref	?OOH	time seen	delay	outcome
29/08/2010	04:20	yes	7.48	3hr 28 min	d/c
28/08/2010	13.09	yes	16.41	4 hr 32 min	admitted
27/08/2010	3.37	yes	4.53	1hr 16 min	d/c
27/08/2010	2.18	yes	5.38	3 hr 30 min	admitted
27/08/2010	0.15	yes	02:10	55 mins	admitted
26/08/2010	13.24	no	15.17	1 hr 53 mins	d/c
25/08/2010	02:05	yes	3.58	1 hr 53 mins	d/c
23/08/2010	06:18	yes	9.52	3 hr 34 mins	d/c
22/08/2010	16.19	yes	17:20	1hr 1 min	d/c
20/08/2010	22.53	yes	9.33	10hr 40 min	d/c
19/08/2010	18.57	yes	21.24	2 hr 27 mins	d/c
18/08/2010	7.15	yes	09.41	2 hr 26 mins	d/c
12/08/2010	17.3	yes	21.42	4 hr 12 mins	d/c
11/08/2010	21.53	yes	23.33	1 hr, 40mins	admitted
10/08/2010	12.43	no	16.25	3 hr 42 mins	d/c
10/08/2010	6.56	no	12.58	5 hrs 2 mins	d/c
09/08/2010	20.22	yes	0.01	3 hrs 41 min	d/c
09/08/2010	3.23	yes	4.41	1hr 18 mins	d/c
08/08/2010	20.36	yes	22:20	1 hr 44 mins	admitted
06/08/2010	5.03	yes	9.16	4 hr 13 min	admitted
03/08/2010	11:20	no	11.33	13 min	d/c
03/08/2010	6.37	yes	11:01	3 hr 24 min	d/c
02/08/2010	1.43	yes	04:16	2 hr 33 min	d/c
01/08/2010	20.35	yes	22:29	1 hr 54 min	d/c

Audit of time from referral to CRHT review August 2012

02-Dec	40	f	19.53	23:00	67 mins
03-Dec	46	f	1.26	03:00	94 mins
03-Dec	38	f	00:32	02:56	144 min
07-Dec	30	f	20:52	21:31	39 mins
11-Dec	21	f	15:34	17:48	144 min
14-Dec	37	f	10:57	12:32	95 mins
14-Dec	41	f	03:15	09:00	345 min
18-Dec	29	f	08:54	10:47	113 min
18-Dec	53	m	20:27	21:55	148 min
20-Dec	45	f	03:37	05:04	87 mins
20-Dec	59	f	23:06	00:50	104 min
23-Dec	21	m	01:34	02:38	64 mins
25-Dec	21	f	08:14	09:48	94 mins
25-Dec	50	f	17:33	18:08	35 mins
26-Dec	53	f	05:55	14:00	365 min
29-Dec	49	f	03:52	04:37	45 mins
30-Dec	38	f	16:20	17:53	93 mins
30-Dec	44	m	21:23	23:21	118 min
30-Dec	20	m	23:53	00:35	42 mins

Audit of time from referral to CRHT review 2015

Date	Time Referred	Time assessed	Interval time
01/03/2015	12.39	14.43	2 hr 4 mins
02/03/2015	2.51	10.1	7 hr 19 min
02/03/2015	6.31	11.04	4 hr 33 min
02/03/2015	10.26	12.03	1hr 37 min
02/03/2015	23.58	1.14	1 hr 16min
03/03/15	13.35	14.56	1 hr 21 min
04/03/2015	9.38	12.38	3 hr
05/03/2015	8.11	09:40	1hr 29 min
05/03/2015	18:00	18.37	37 min
07/03/2015	2.51	4.21	1hr 30 min
07/03/2015	9.42	13.26	3 hr 42 min
07/03/2015	22.03	22.54	51 min
07/03/2015	23.25	1.45	2 hr 20 min
08/03/2015	03:33	4.34	1hr 1 min
09/03/2015	11.55	17.55	6 hr
09/03/2015	15.31	16.46	1hr 15 min
09/03/2015	15.25	17.45	2 hr 20 min
10/03/2015	20.08	22.26	2hr 18 min
10/03/2015	20.46	1.34	4 hr 48 min
10/03/2015	21.54	23.02	1hr 8 min
14/03/2015	06:00	10:10	4 hr 10 min
14/03/2015	23:35	1.48	2 hr 47 mins
15/03/2015	17.59	20.36	2 hr 37 min
18/03/2015	12.54	14.17	1 hr 23 min
20/03/2015	7.26	9.02	1 hr 36 min
21/03/2015	21.16	23.25	2 hr 9 min
23/03/2015	19.08	22.35	2 hr 27 min
25/03/2015	20.41	22.16	1hr 35 min
25/03/2015	21.36	10.23	12hr 47 min
27/03/2015	08:37	11.21	2 hr 44 min
27/03/2015	19.27	21.42	2 hr 15 min
28/03/2015	01:42	03:13	1 hr 31 min
30/03/2015	12:40	14.14	1hr 34 min
30/03/2015	14.14	18.21	4 hr 7 min
31/03/2015	18:02	22:40	4 hr 38 min

APPENDIX 6

Audit of Psychiatric Attendances to A&E at the James Paget Hospital, 1st May – 1st August 2009
Dr Donna Wade – Consultant in Emergency Medicine

Introduction

The aims of this audit was to look and the number of patients attending A&E with psychiatric diagnoses over a 3 month period, the outcome (discharge from A&E, referral to psychiatry or admission) for these patients, and the time taken for psychiatric review. The management of patients under the age of 18 attending the Department with psychiatric diagnoses was also reviewed.

Method

Using the EDIS system, all patients attending the A&E Department between 1st May and 1st August 2009 with a Psychiatric Diagnosis. Or with a diagnosis of overdose were identified. The following data was then obtained for these patients:

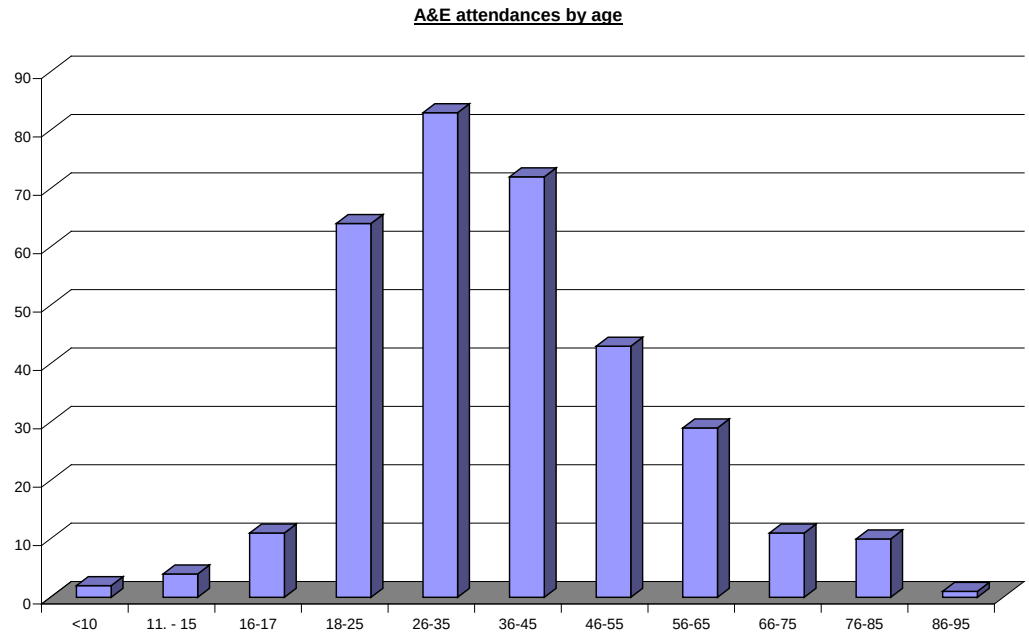
- Age and sex
- Diagnosis
- Outcome (admitted, referred or discharged)
- Time from referral to psychiatric review if referred, broken down by time of day

Results

393 patients attended the Department with Psychiatric diagnoses over this time-frame. Of these 72 were related to alcohol, leaving 321 'true' psychiatric attendances over the 3 months of the audit.

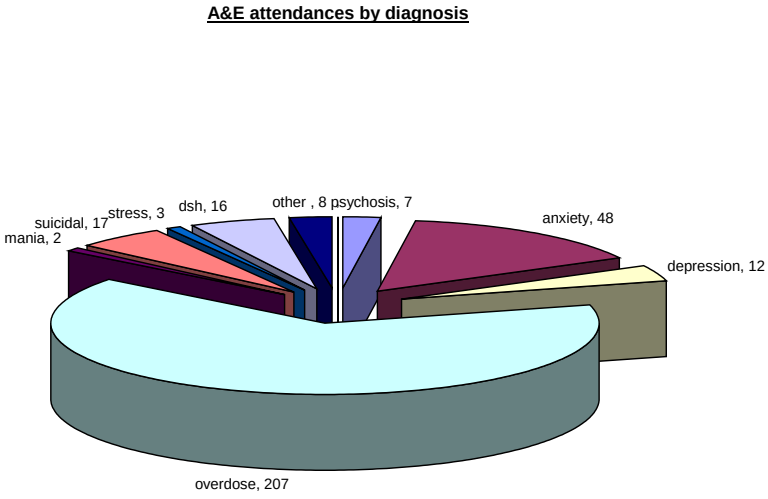
Demographics

188 female and 213 male patients attended the department over the audit period. The ages of the patients attending are shown below.



Diagnosis

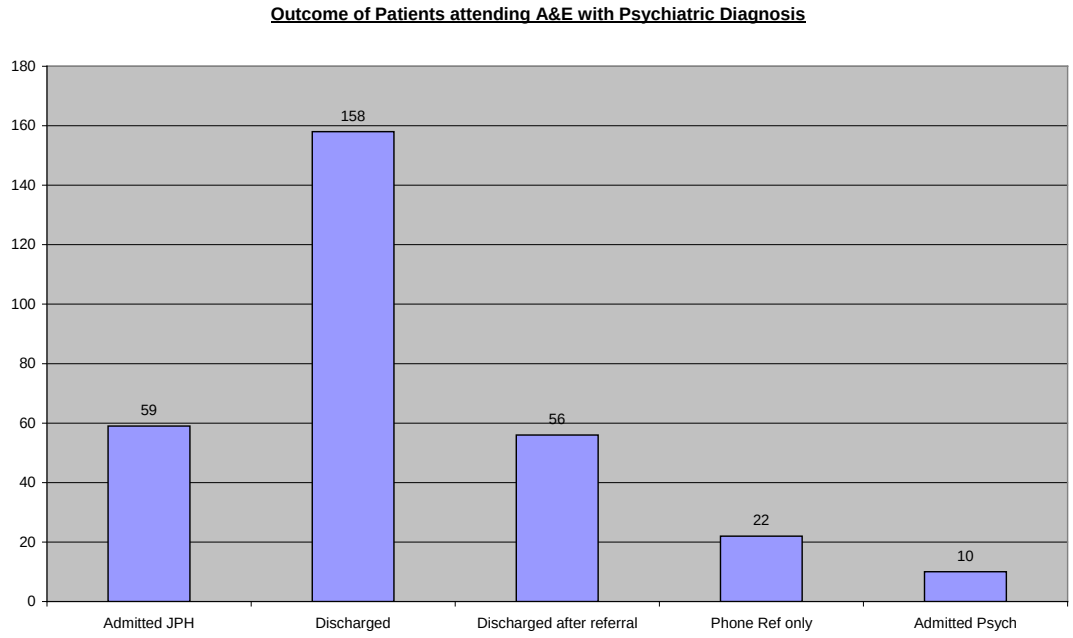
Diagnoses are shown below:



65 % of attendances were after an overdose and a further 5% after another method of self-harm.

Referral patterns

Of the patients attending A&E with non-alcohol related problems for whom information was available, 158 were discharged from the department, 59 were admitted to wards, and 88 were referred to psychiatry. Of the 88 who were referred, 56 were subsequently discharged from the department, 22 were not seen in the department after referral and 10 were admitted to a psychiatric unit.



CAMHS patients

Of the 16 patients under the age of 18 who attended the department:-

8 were admitted for CAMS follow-up the next working day

2 patients with anxiety disorder were referred to their GPs

1 patient with minor DSH and a previous history of the same was discharged with no follow-up

5 patients after overdoses (all aged 17) were discharged home with GP follow-up, one after discussion with the Home Treatment Team.

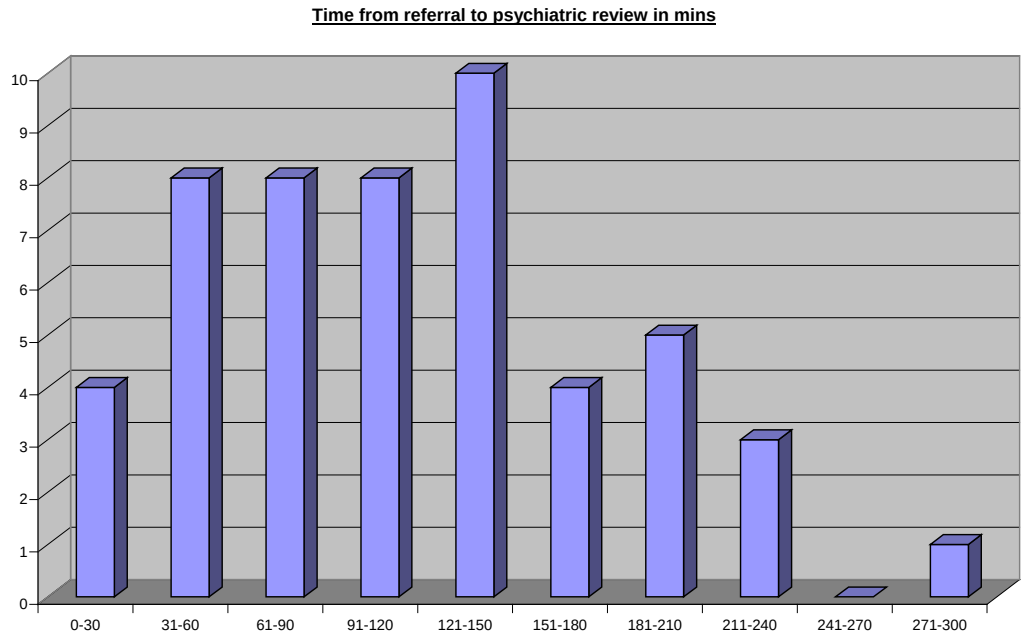
1 patient was admitted to the A&E Obs bay overnight and discharged the next working day after HTT review.

1 patient (17y.o.) was discharged home with next day CPN follow-up.

1 patient (15) was allowed to self-discharge herself after an overdose without psychiatric review, but after an appropriate period of observation.

Time taken from referral to Psychiatric Review

Data was available for 52 of the 68 patients referred and seen in the Department. Of these, 28 were seen within 2 hours, 14 within 2-3 hours, 8 within 3-4 hours, and 2 patient waited more than 4 hours to be seen. The mean time was 106 minutes (range 20-280 minutes).



Looking at specific time of referrals, 10 patients were referred between 08.00 and 17.00, 17 patients between 17.00 and 00.00, and 25 patients between 00.00 and 08.00.

The mean time for review for patients referred between 08.00 and 17.00 was 141 minutes (range 20-280 minutes), for patients referred between 17.00 and 00.00 was 119 minutes (range 43 – 226 minutes), and for patients referred between 00.00 and 08.00 was 114 minutes (range 32 – 368 minutes).

Incidental Findings

A significant number of patients self-discharged from the Department before being treated for their overdose or having their mental state adequately assessed. This is concerning as no risk assessment for further DSH had been performed on the majority of these patients, and the police were only informed about a small number deemed to be at highest risk.

Conclusions

A large proportion of the patients attending A&E with psychiatric problems do so after either overdoses or episodes of DSH.

Of the 246 patients with psychiatric diagnoses deemed medically fit for discharge from A&E, 36% were referred on to psychiatric services for review. Of these 75% were reviewed in the Department, but 25% (22 patients) were discharged home with follow-up by psychiatric services at home at a later date.

A proportion of these patients may have been known to psychiatric services, and therefore this may have been appropriate, but in general discharging patients deemed to be at high risk by A&E staff without a psychiatric review in the Department is potentially dangerous, and this should be addressed.

There is a perception among staff in the A&E Department that there are often prolonged delays for patients to be seen by Psychiatry, particularly overnight. This audit shows that waiting times are actually shorter overnight, and overall 54% of patients were assessed within 2 hours. Some patients are, however, still facing prolonged delays to be reviewed by psychiatric services.

The management of patients falling under the CAMS remit remains a concern. The Departmental policy is that all patients attending with an overdose or episode of DSH under the age of 18 should be admitted overnight and reviewed by CAMS the next working day. This did not happen in at least three patients over the audit time-frame and one patient was allowed to self-discharge, despite being under the age of 16. The management of these patients needs to be addressed within the A&E Department.

Proposed actions to be taken

1) Audit findings to be discussed at Psychiatric Liaison meeting.

2) Delays in psychiatric review to be discussed with psychiatric services, although this is intermittent and not as wide-spread as perceived by A&E staff.

3) Paediatric nursing staff and junior doctors to be educated re appropriate management of patients under the age of 18 attending with an episode of DSH or overdose.

4) Education of medical staff to be continued re appropriate referrals to psychiatric services using the SAD score, and GP follow-up of low risk patients. Education of medical and nursing staff re adequate risk assessment of patients wishing to self-discharge.

5) Appropriateness of the discharge of high-risk patients from A&E without a psychiatric review to be discussed at psychiatric liaison group meeting.

APPENDIX 7

Audit of referrals to CRHT from JPH, July 2014 – Dr Johnson Anthony, CT1 psychiatry

- Referrals to CRHT FROM JPH A&E were audited from 1st March – 31st March 2014

- Under coding
  - Psychiatric conditions- 134 patients(od with suicidal intent, suicidal risk, DSH)
  - Poisoning- 67 patients (deliberate od)

Referrals to CRHT during this period

- Total – 45
- Assessed by CRHT
  - Within 4 hrs- 22 seen (48.88%)
  -
  - Over 4 hrs – 9 seen (20%) varying from 4hr 40min to 7hr 56min
  - Unclear – 9 (from records) (20%)
  - Telephone consultations – 5 (11.11%)
  - From above one got admitted to acute psychiatric ward informally

SAD scores indicated - 100

- Available - 39
- Not available - 61(few admitted under medics/paeds)

Criteria

National standards – 4 hours

Inferences

- In recording the time of CRHT/htt, the time recorded in the system is when they start to type, but the patient would have been seen at least 30-60 minutes before this, but difficult to audit the exact time.

Recommendations

- CRHT to find ways to improve the timing to meet national standards
- Clear recording of timing of referral by A&E and assessment timing by CRHT
- To consider improving coding system by A&E
  - Eg: (1) no alcoholism under psychiatric conditions

(2) avoid deliberate overdose under poisoning

- Alcoholism to come under different coding
- In audit cycle – consider to include the number of admissions to acute psychiatric wards both informally and formally
- Joint training needs (as many referrals done on the basis of SAD score score ?Above 6) to improve the qualitative outcome.
- To take into account of the number of patients discharged from A&E back to GP care.

APPENDIX 8

Mental Health Attendances at JPUH Emergency Department
April 1014 – March 2015 - Barry Pinkney

Categories of Attendance	April 2014	May 2014	June 2014	July 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Comments in regards to additional Mental Health support within ED
Personal History of Self harm	12	13	10	6	3	13	11	8	4	15	14		These patients are signposted to community services and key individuals to support patients in reducing their self-harm attempts therefore reducing attendances
Admitted	2	2	2	0	0	5	1	1	0	2	2		Admission to JPUH - patients are followed up next day to support early discharge with follow up.
Self-Harm Overdose	51	32	32	34	29	43	36	41	41	44	43		Patients assessed and discharged with support services based on risk assessment and medically stable. Additional support has provided timely discharges
Admitted JPUH	20	10	9	11	9	10	13	7	6	13	7		Followed up next day with reduced LOS
Anxiety	16	9	24	24	13	20	11	17	14	17	18		Although not seen currently these are the patients that require signposting to support and prevent escalation to mental health services (the future patient) additional support would allow follow up.
Suicide Risk	8	11	13	14	12	10	17	15	9	9	6		Seen as a priority – reduced numbers of recent as pathway relaunched with EOE ambulance and NSFT.
Manic/psychotic episodes	19	17	14	13	17	13	9	15	21	15	13		These patients have escalated behavioural concerns and require timely response in an ED.
Admission to Mental Health Hospital	1	2	2	6	4	2	5	5	6	3	2		Support to access and to make the correct decision with support of acute services
Left with police	0	2	0	0	0	0	0	0	1	2	1		
Total	**106**	**82**	**93**	**91**	**75**	**100**	**84**	**96**	**89**	**100**	**94**		

APPENDIX 9

CASE STUDIES OF PATIENTS WITH PROLONGED WAIT FOR CRHT 2015

Case Study 1

15 y.o. female

Attended ED on 25/3/15 at 21.11 with support worker.

Long history of mental health problems, had been an inpatient in a CAMHS unit in another area for 2 years, now living in Specialised Children's Home with support workers.

Brought to ED as behaviour becoming increasingly bizarre. Referred to mental health team at 21.36 by ED Consultant. CRHT unwilling to see due to age. Social work team concerned about sending home without CAMHS assessment. Unsuitable for Adolescent Unit due to behaviour, unable to admit to observation bay for same reason.

Patient kept on mattress on floor in secure room overnight, with security porter in attendance.

Assessed by CAMHS team at 10.23, discharged back to home at 10.55

Time from referral to assessment – 13 hours 19 minutes

Case Study 2

50 year old female

History of bipolar disorder

Physically disabled with obesity and poor mobility, lives with carer.

Attended ED on 27/3/15 at 22.28 with a history of thoughts of self-harm and harming carer. Stating felt unsafe to return home.

Seen by A&E doctor at 01.24, referred CRHT at 01.42. Time seem not documented but decision recorded at 03.13 by CRHT assessor that patient needed to be admitted to an inpatient bed.

Entries by A&E nursing staff during day recording contact with mental health team and challenges of finding a bed.

Reassessed by CRHT at 18.47. Documented that patient has been throwing objects in ED, has tried to stab herself recently and is eating little with delusional thoughts regarding food and eating. Decision recorded again that an inpatient bed is needed. Mental Health Act Assessment called at 19.23 – reason unclear, possibly in order to expedite bed.

Time of MHA Assessment unclear, but patient discharged home with carer at 11.19 on 29/3/15. Reasons for discharge documented include concerns that psychiatric inpatient unit would be unable to manage her due to her obesity and poor mobility, and that she would therefore be better managed at home.

Time from referral to CRHT to decision to discharge home – 33 hours 37 minutes

Case Study 3

38 year old male, known schizophrenia

Attended ED at 14.09 on 14/2/15. Seen by A%E doctor at 15.21 and referred to CRHT

Seen by psychiatry FY2 at 22.52 (as no assessor available), referred back to medical team as patient was complaining of pr bleeding. Seen by medical team who declared him medically fit for discharge at 23.47

Reassesed by psychiatry FY2, who requested patient remain in A&E for an assessment by CRHT in the morning – unclear why.

Reviewed by CRHT at 10.08, and decision made to admit – transferred to inpatient bed 10.20

Time from referral to CRHT to assessment by assessor able to make decision to admit – 18 hours 47 minutes

Case Study 4

32 year old female

Presented initially with pseudoseizures, then proceeded to self-harm in ED.

Referred CRHT at 21.10 on 16/3/15. Informed no assessor available overnight.
Security porter remained with patient for majority of night due to repeated attempts to self-harm and abscond when left alone.

Seen by CRHT at 09.16, and subsequently discharged home.

Time from referral to assessment – 11 hours, 54 minutes

Case Study 5

28 y.o. female, attended ED at 21.53 on 16/1/15 with police escort.

History of depression and previous suicidal attempts. Had been assessed at Carlton Court earlier that day but declined admission.

Seen by A&E doctor at 00.20 and MHA assessment called. Informed no social worker currently available to attend.

Patient kept in ED overnight, documented to be aggressive towards staff, and to be attempting to leave ED.

Liason psychiatry nurse asked to see patient at 08.00, became apparent that MHA assessment had NOT been called overnight as ‘not able to facilitate due to staffing’. Liason psychiatry nurse attempting to call MHA.

Patient became abusive and violent towards porters and assaulted one of them at 08.59. Arrested by police and taken to police station for assessment there.

Time from referral to removal from ED – still without a MHA assessment having been called – 11 hours, 54 minutes

Case Study 6

18 year old female

Attended ED after overdose at 03.00 on 26/1/15. Medically fit for assessment at 07.08 and referred CRHT. Seen at 08.48 and decision made to admit to an inpatient bed.

No bed available in area, remained in ED until 18.12 when bed eventually became available in area.

Time from assessment to admission to bed – 9 hours 24 minutes

APPENDIX 10

TRUST SELF-DISCHARGE FORM

SELF DISCHARGE FORM

DT28

NHS number ……..

Name of patient ……..

Address: ……..

Date of birth: ……..

Hospital:

Ward:

Date: Time:

BOX 1 – CAPACITY ASSESSMENT	**YES**	**NO**
Always presume capacity unless proved otherwise. Remember that lack of capacity can only be proved if a patient has a temporary or permanent disturbance of the mind or brain.		
Can the patient understand the information relevant to this decision?		
Can the patient retain that information?		
Can the patient use or weigh that information as part of the process of making the decision?		
Can the patient communicate his/her decision?		
If YES to all 4 criteria above the patient has capacity. Complete BOX 2 **Please document below the basis of your capacity assessment – e.g. the patient is fully engaged in conversation and asking appropriate questions.**		

If NO to ANY of the 4 criteria above the patient lacks capacity and must be prevented from leaving hospital - complete BOX 3. Please note that the lack of capacity from this assessment applies to their ability to make a decision about self-discharging themselves from hospital ONLY. Please document below the reason that you feel the patient lacks capacity.

BOX 2

To be completed when the patient has been assessed as HAVING CAPACITY to decide to self-discharge against medical advice	**TICK**
Explanation of the necessary treatment required and the consequence of the patient refusing the treatment have been given and are understood	
Other options which may be acceptable to both the clinicians and the patient have been explored with the patient	

Where the consequences of refusing treatment are serious or life threatening discussion and assistance have been sought from the consultant and other relevant professions such as the Mental Health Team if indicated. **NB patients at ongoing risk of self-harm should not be allowed to self-discharge without an assessment by the mental health team.**	
The self-discharge release from responsibility for discharge for overleaf is completed by the patient whenever possible and retained in their medical record. If the patient refuses then the form should still be completed by the responsible medical professional and the refusal to sign documented.	

BOX 3

To be completed when the patient has been assessed as LACKING CAPACITY to decide to self-discharge against medical advice	**TICK**
Staff utilise persuasion, calming and de-escalation techniques	
Referral to the Mental Health Team is considered as appropriate	
Initiation of DOLS procedure considered as appropriate	
If the patient has left the ward staff then JPUH Missing Persons Policy utilised and security informed	
Escalate to Site Management	

Outcome	**TICK**
Patient with capacity self-discharged – Consider GP contact/Medications/OPA– we remain to provide a duty of care	
Patient with capacity decided to remain in hospital	
Patient without capacity decided to remain in hospital	
Patient without capacity is retained in hospital	
Patient left hospital without informing staff (consider informing police and / or next of kin if lack of capacity or concerns re mental health)	

Signed: …… Print name: …… Designation: ……..Time: …….

To be completed by the clinician (in discussion with the patient) whenever possible prior to the patient taking his/her self-discharge from the hospital

I, the undersigned hereby declare that I am discharging myself from this hospital and that I understand the consequences of failing to follow the medical advice given to me which might result in significant disability or even death.

I understand that the condition I have been diagnosed with is:

I understand the treatment proposed is:

I understand that the risks of refusing treatment are:

I understand I can change my mind at any time and return for treatment.

Patient's signature: ……

Witness: ……

Designation of witness: ……..

Date: …… Time: ……

This form when completed must be retained in the patient's medical record and also written documentation entered in the patient's medical records. Please remember that this document may be required in court and should be completed fully and legibly (printing where necessary).

APPENDIX 11

AUDIT OF SELF DISCHARGE DOCUMENTATION JPUH ED
Dr Donna Wade 19/2/15

PART 1 – PATIENT CODED AS 'LEFT BEFORE TREATMENT'
1st- 31st January 2015

35 patients self-discharged from the ED during the study period. These patients were identified from EDIS using the diagnosis 'left without treatment' as a search term.

Of these, 24 left without informing staff, or without engaging in conversation.

1 patient was intoxicated and swearing, refused to talk to staff, and left with a family member.

The police were informed re 2 patients – one who had a head injury, and one who had self-harmed and left before a risk assessment could be conducted.

Of the remaining 8 patients, 6 had capacity documented, and 1 had 'alert and orientated' documented, indicating that the patient was likely to have capacity.

6 had appropriate advice documented re the risks of discharging themselves, and follow-up plans

6 were documented to have completed a self-discharge form.

Conclusions

ED staff generally show a good awareness of the importance of assessing capacity in patients who wish to self-discharge, and of the importance of giving them appropriate information to inform their decision and a safety-net should they wish to return.

Ongoing education is needed to ensure that ALL patients who wish to self-discharge have a form completed, which includes a capacity assessment and a documentation of information given. The Trust is planning to roll out training on the new self-discharge form in the coming months.

PART 2 – PSYCHIATRIC PATIENTS DOCUMENTED TO HAVE SELF DISCHARGED OR LEFT WITHOUT TREATMENT 1ST NOV 2014 – 31ST JAN 2015

14 Patients in total. Outcomes were as follows:

1) Police contacted

The police were informed about 6 patients who had presented with suicidal ideation or self-harm, and had left the department before being seen by a doctor.

In 2 cases there is no further documentation – likely to indicate that the police performed a welfare check and let the patient at home.

In 1 case the police were contacted and despite concerns raised by ED staff refused to perform a welfare check, for reasons which are unclear.

In 2 cases the patients were returned to the ED for further assessment

In 1 case the crisis team was informed as well as the police, and the crisis team contacted the patient at home for further assessment.

2) Self Discharge form signed and allowed home appropriately

5 patients were deemed as low risk of further self harm, and had self-discharge forms signed before they left the ED. In 1 case, a patient with significant depression was discharged home with a competent adult and crisis team follow-up was arranged at home.

Capacity is documented in 3 out of the 5 patients. This may have been documented in the self-discharge forms of the additional 2, but unfortunately these are not available for review.

3) Incorrect coding as psychiatric patients

1 patient coded as 'Psychiatric condition unspecified' has no documentation. However, this was a patient who has attended 18 times in the last year with pseudoseizures, so it is reasonable to assume that this was the diagnosis on this occasion also. Nevertheless, documentation should have been completed to this effect.

1 patient had attended because she was symptomatic having taking several recreational drugs, without suicidal intent and left after seeing a doctor because she was unwilling to stay in for observation. She did not notify staff so no self-discharge .form was signed.

4) Other

1 patient attended with mild paranoia without any suicidal ideation. He was declared medically fit for discharge, but the police had requested that he was kept in the ED until they came to see him, for reasons that are unclear. He left the ED without notifying staff, and the police were informed.

Conclusions

Having reviewed the notes, I am confident that all patients in this audit were managed safely. Documentation was inadequate in 1 case out of 14, and medical staff need to be reminded to document capacity, although this is now mandatory in the new self-discharge form.

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the briefings, scrutiny topics and dates below.

Proposed Forward Work Programme 2015

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
28 May 2015	Changes to services arising from system wide review in West Norfolk –consultation with the committee. Diabetes care within primary care services in Norfolk – discussion with NHS England East Anglia Area Team, West Norfolk Clinical Commissioning Group and providers of diabetes facilitators programme (central Norfolk) Consultation on long term plans to maintain and improve access to primary care services in Norwich and surrounding areas – potential consultation by NHS England EAAT in May or July 2015, depending on the outcome of a strategic review by Enable East (starting March 2015).	*Potential consultation in May or July 2015 depending on decisions by NHS England*
16 July 2015	NHS workforce planning in Norfolk - report of the scrutiny task & finish group. Changes to mental health services in west Norfolk (development of dementia services) – consultation with the committee regarding permanent changes following the trial period ending in March 2015.	*Public consultation to be launched in June 2015*
3 Sept 2015		
15 Oct 2015	Policing and Mental Health Services - an update from the Police & Crime Commissioner for Norfolk, Norfolk and Suffolk NHS Foundation Trust and Norfolk Constabulary (further to the presentation given to NHOSC in October 2014).	

Committee members requested information on the following items (to be included in the NHOSC Briefing:-

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Provisional dates for reports to the Committee / items in the Briefing 2015-16

3 Dec 2015 – Stroke Services in Norfolk – update (12 months after the responses to stroke recommendations, presented to NHOSC 27 November 2014).

Jan 2016 – Development of Dementia Services in West Norfolk – final consideration of the CCG's proposals

Feb 2016- Ambulance response times and turnaround times in hospitals in Norfolk (an update to the East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and Clinical Commissioning Group report presented in February 2015)

NHOSC Scrutiny Task and Finish Groups

Task & finish group	Membership	Progress
NHS Workforce Planning in Norfolk	Cllr Michael Chenery of Horsbrugh Cllr Alexandra Kemp Cllr Robert Kybird Cllr Nigel Legg Cllr Margaret Somerville (Chairman) Alex Stewart – Healthwatch Norfolk	The Group met NHS representatives on 10 Feb, 20 & 31 March and is on schedule to report back to NHOSC in July 2015.

Main Committee Members have a formal link with the following local healthcare commissioners and providers:-

Clinical Commissioning Groups

North Norfolk	-	Mr J Bracey (substitute M Chenery of Horsbrugh)
South Norfolk	-	Dr N Legg (substitute Mr R Kybird)
Gt Yarmouth and Waveney	-	Mrs S Weymouth

		(substitute Mrs J Chamberlin)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mr A Wright)
Norwich	-	Mr J Bracey (substitute Mrs M Somerville)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mr A Wright (substitute M Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Somerville)
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Somerville
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Somerville)

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Glossary of Terms and Abbreviations

A&A	Access and Assessment
AASP	Admission avoidance support package
AAT	Access and Assessment Team
ADHD	Attention deficit hyperactivity disorder
ADM	Admissions
A&E	Accident and Emergency
AMHP	Approved Mental Health Practitioner
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive behavioural therapy
CC	Care Co-ordinator
CCG	Clinical Commissioning Group
CEM	College of Emergency Management
CFYP	Children, families and young people
CLL	Complexity in later life
CPA	Care Programme Approach
CPN	Community psychiatric nurse
CPR	Cardio pulmonary resuscitation
CQC	Care Quality Commission
CQRM	Clinical Quality Review Meeting
CQUIN	Commissioning for Quality and Innovation
CRHT	Crisis Resolution & Home Treatment
D/C	Discharged
DCLL	Dementia & complexity in later life
DECT	Digital enhanced cordless telecommunications
DETOC/DTOC	Delayed transfer of care
DIST	Dementia Intensive Support Team
DOL	Deprivation of Liberty
DSH	Deliberate self harm
EAAT	East Anglia Area Team
EADU	Emergency Assessment and Discharge Unit
ED	Emergency Department
EDT	Emergency Duty Team
EDIS	Emergency department information service (computer system)
EEAST	East of England Ambulance Service NHS Trust
ENP	Emergency Nurse Practitioner
Est	Establishment (staffing)
FACT	Flexible Assertive Community Treatment
FAP	Frequently attending patient

GP	General Practitioner
GY	Great Yarmouth
GYW	Great Yarmouth and Waveney
GY&WCCG	Great Yarmouth and Waveney Clinical Commissioning Group
GY&W JHSC	Great Yarmouth and Waveney Joint health Scrutiny Committee (which includes Members from Norfolk and Suffolk Health overview and Scrutiny Committees)
HALO	Hospital ambulance liaison officer
HCA	Health Care Assistant
IAPT	Improving Access to Psychological Therapies
ITU	Intensive Care Unit
JPUH	James Paget University Hospital
LCP	Lead Care Professional
LD	Learning difficulties
LGB	Lesbian, gay, bisexual
LINk	Local Involvement Network
LOS	Length of stay
MAU	Medical Assessment Unit
MCA	Mental Capacity Act
MH	Mental Health
MHA	Mental Health Act 1983
MHLT	Mental Health Liaison Team
MHP	Mental Health Practitioner
MSE	Mental state examination
NCC	Norfolk County Council
NCH&C	Norfolk Community Health and Care NHS Trust
NFA	No fixed abode
NHOSC	Norfolk Health Overview and Scrutiny Committee
NICE	National Institute of Health and Clinical Excellence
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NRLS	National report learning system
NRP	Norfolk Recovery Partnership
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
OCCU	Occupied
OD	Over dose
OOA	Out of area
OPCC	Office of the Police and Crime Commissioner
OSC	Overview and Scrutiny Committee
PCR	Pharmacy care record
PCR	Police Control Room
PDC	Professional development centre

PIC	Police Investigation Centre
PICU	Psychiatric intensive care unit
PPPG	Professional Policies Protocols and Guidelines
PSYLIA	Psychiatric liaison
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
QGC	Quality Governance Committee
RAG	Red, amber, green
RATS	Rapid Assessment and Treatment System
RCA	Root cause analysis
RMN	Registered Mental Nurse
RN	Registered Nurse
SAD	A clinical assessment tool to determine suicide risk
SH	Self harm
SHO	Senior House Officer
SI	Serious incident
SMHP	Suffolk Mental Health Partnership
SNCCG	South Norfolk Clinical Commissioning Group
SSRIs	Selective serotonin re-uptake inhibitors or serotonin-specific reuptake inhibitors - a class of compounds typically used as antidepressants
TBC	To be confirmed
UEA	University of East Anglia
WAV	Waveney
WTE	Whole time equivalent