EXECUTIVE COUNCIL

PUBLIC

Title:	Report and Action Plan relating to a significant adverse event in August 2017 (patient RO102018)
Paper Number:	142/2018
Date:	24th October 2018
Responsible Director:	Director of Health Services
Report Author:	Director of Health Services
Portfolio Holder:	MLA Ian Hansen, Health and Social Services Portfolio holder
Reason for paper:	This paper is submitted to Executive Council: For policy decision (including budgetary policy) For policy update/information
Publication:	Yes wit redactions as highlighted **Not Recommended:** *Under Executive Council Standing Order 23(2), Executive Council must have regard to the categories of exempt information in Schedule 3 to the Committees (Public Access) Ordinance when determining if information should be withheld* *The category which is potentially relevant to this paper is paragraph 7 in schedule 3 'Information about Individuals'*
Previous papers:	**None**
List of Documents:	Appendix 1: Significant Adverse Event Review – Mental Health. Commissioned by the Falkland Islands Government. (NOT for publication) Appendix 2: Significant Adverse Event Review – Executive Summary. Appendix 3: Action Plan

1. Recommendations

Honourable Members are recommended to approve:

(a) Note the contents of the report and action plan

(b) Approve the request for future funding to assist with fulfilling the requirements of the Action Plan

(c) Note that policy work will follow in future Executive Council papers once work this is further developed.

Executive Council further resolved that:

(d) A report on progress of the Action plan (appendix 3) is submitted to Executive Council in six months.

2. Additional Budgetary Implications

The additional budgetary request cannot be identified within budgets already allocated for the 2018/19 financial year.

	2018/19	**Annual Recurring**
Operating Budget	£40,000	none

3. Executive Summary

3.1 Following the tragic death of RO102018 an independent review was commissioned. The scope and level of the review was to review the care and management of RO102018 to consider what could be learned both in terms of specific features of her care and management and more generally to recognise good practice and identify areas for improvement.

3.2 The professionals identified came from NHS Scotland, although their work in the Falkland Islands was undertaken independently from their roles within NHS Scotland.

3.3 The independent reviewers stated that overall the care and treatment being provided for RO102018 was appropriate for the management of someone with the complex difficulties that she presented with.

3.4 The independent reviewers looked into nine areas and made recommendations for improvements under each area.

3.5 An Action Plan has been developed and work has already commenced in line with this.

3.6 In order for some items in the Action Plan to be completed, particularly the development of an overall mental health strategy covering both service delivery and public health, there will be the need for some additional staffing resource to back fill the Senior Community Psychiatric Nurse's work to enable her to work on this. Costings for this are included in this paper, but it is not yet possible to identify exactly at which point this will be required. As far as possible this work will be completed alongside normal working.

Additional cover for the Chief Medical Officer and provision of remote medical advice on this substantial piece of work is also likely to be required.

3.7 Initially the Action Plan will be monitored to ensure progress is being made in a timely and appropriate manner through the Health and Medical Services Committee (HMSC).

Once there is an Adults Safeguarding Board in place (which is dependent on the agreement of the Adult Safeguarding Bill being agreed) monitoring of the Action Plan will transfer to that forum.

3.8 The CEO and the MLA responsible for the Health and Social Services Portfolio will receive regular updates on the progress of the action plan and any barriers to its progress.

4. Background and Links to Islands Plan and Directorate Business Plan/s

4.1 RO102018 had been an inpatient at the King Edward the VII Memorial Hospital (KEMH) from 20th July 2017. Their discharge was planned for the 23rd August. RO102018 left the hospital on the 22nd August with the agreement of staff but did not return at the expected time. A search followed but RO102018 was not found until the flowing day, 23rd August 2017 and was pronounced dead at the KEMH following resuscitation attempts.

4.2 RO102018 had a history of complex mental health problems.

4.3 Following the death of RO102018 an independent review was to assess. The scope and level of the review was commissioned the care and management of RO102018 to consider what could be learned both in terms of specific features of her care and management and more generally to recognise good practice and identify areas for improvement.

4.4 No information was available to suggest the FIG had carried out such an independent review previously related to any other case.

4.5 Care was taken to ensure that the professionals invited to undertake the review were not known to anyone involved in the care of RO102018 and that they had appropriate knowledge and experience to undertake such a review.

4.6 The professionals identified came from NHS Scotland, although their work in the Falkland Islands was undertaken independently from their roles within NHS Scotland.

4.7 Within the Findings and Recommendations of the report the authors stated that; ‘The need to avoid where possible lengthy in-patient stays in the management of an individual with her complex difficulties is recognised as current best practice. Patterns of escalating risk-taking behaviour whilst an in-patient in such individuals is often seen and an attempt to move her care beyond Hospital is in keeping with current best practice.

Overall the care and treatment being provided for RO102018 was appropriate for the management of someone with the complex difficulties that she presented with.’

4.8 The independent reviewers looked into nine areas and made recommendations for improvements under each area. Detail of the findings of the independent reviews and their recommendations can be found in the attached reports (Appendix 1 and 2).

4.9 The senior team at the hospital formulated an initial action plan, which was then discussed with the visiting psychiatrists, and the Action Plan further developed in the light of this.

4.10 Work has already commenced in line with the action plan (Appendix 3)

4.11 In order for some items in the Action Plan to be completed, particularly the development of an overall mental health strategy covering both service delivery and public health, there will be the need for some additional staffing resource to back fill the Senior Community Psychiatric Nurse's work to enable her to work on this. Costings for this are included in this paper, but it is not yet possible to identify exactly at which point this will be required. As far as possible this work will be completed alongside normal working. Additional cover for the Chief Medical Officer and provision of remote medical advice on this substantial piece of work is also likely to be required.

4.12 The importance of the Action Plan being monitored to ensure progress is being made in a timely and appropriate manner is recognised and the plan has been added to the Health and Medical Services Committee (HMSC) agenda as a standing item for this purpose.

4.13 Once there is an Adults Safeguarding Board in place (which is dependent on the Adult Safeguarding Bill being agreed) monitoring of the Action Plan will transfer to that forum.

4.14 The HMSC meets on a quarterly basis and it is anticipated that the Safeguarding Adults Board will meet with the same frequency, ensuring the Action Plan is regularly reviewed.

4.15 The CE and the MLA responsible for the Health and Social Services Portfolio will receive regular updates on the progress of the action plan and any barriers to its progress.

4.16 Once the Mental Health Strategy has been developed this will be bought to Executive Council.

4.17 This work is in line with the Islands Plan commitment to health and community wellbeing, being in line with the stated vision to '*maintain and improve our existing resources and services, and invest in developments to support the current and future wellbeing of everyone in the Falkland Islands*' (The Islands Plan 2018 – 2022 page 21). It is in line with the commitment that in the current assembly the Government will '*Develop and implement a mental health strategy that recognises the importance of good mental health*' (The Islands Plan 2018 – 2022 page 22)

5. Options and Reasons for Recommending Relevant Option

5.1 This Executive Council paper is predominantly provided to inform Honourable Members about the findings outlined in the Significant Adverse Event Review and the resulting action plan. A request is also made for additional funding to backfill two key

members of staff to fulfil some on requirements of the Action Plan, and to provide external professional support towards the development of the revised Mental Health Strategy

6. Resource Implications

6.1 Financial Implications

Some aspects of the Action Plan have already been budgeted for in the 2018/2019 budget process including provision for specific mental health training and the alteration of a single room on the inpatient ward at the KEMH to create an 'Admissions Suite'.

It is anticipated that in order to deliver the Mental Health Strategy in a timely manner additional staffing resource will be needed to either back fill key staff positions to enable existing staff to undertake this and / or use remote specialist advice.

The cost of backfilling the Senior CPN for a period of three months would be £17,315 as this would require engaging a locum person and so the cost of one return flight has been included in the calculation.

The cost of backfilling the CMO with a locum for one month would be £15,565, again the cost of one return flight has been included.

Remote specialist advice is usually charged at around £750 per session (a session is half a working day).

The exact timing of requiring this extra staffing and the duration it will be needed for will be identified further on in the process once the Senior CPN has started to develop the work. As it is not possible to give a precise estimate, a working budget of up to £40,000 to be split between back fill for the SCPN and CMO and consultation for remote specialist advice is requested.

The additional budgetary request cannot be identified within budgets already allocated for the 2018/19 financial year.

6.2 Human Resource Implications

At this point there have not been any additional Human Resource implications identified, other than the additional staff outlined above to support the process of developing the Mental Health Strategy. However once the Mental Health Strategy has been developed additional staffing needs may be identified, in which case these would be requested once identified.

6.3 Other Resource Implications

None identified at this time.

7. Legal Implications

7.1 The transfer of monitoring the Action Plan from the HMSC to the Adult Safeguarding Board is dependent on the Safeguarding Adults Bill progressing.

8. Environmental & Sustainability Implications

8.1 None

9. Significant Risks

9.1 The independent review described the care delivered as ‘appropriate’, however following the recommendations of the report through completing our Action Plan should improve safe treatment and support for some of the most vulnerable in the Falkland Islands.

10. Consultation

The content of this paper has been discussed with MLA Hansen and MLA Spink (Portfolio Holder and Deputy Portfolio Holder for Health and Social Services).

The parents of RO102018 are aware that an Executive Council paper is being submitted. They have been consulted regarding which aspects of the submission will be in the public domain through publication.

Health and Social staff were involved in the Significant Adverse Event Review and appropriate staff involved in the formulation of the action plan.

Members of HMSC have been provided with the Executive Summary of the Significant Adverse Event Review and the most recent version of the Action Plan.

11. Communication

11.1 The parents of RO102018 are keen to closely monitor the progress of the Action Plan and have been meeting with the DHSS, AG, CMO and Governance Manger of the KEMH for this purpose.

142/18
Appendix 2

SIGNIFICANT ADVERSE EVENT REVIEW – EXECUTIVE SUMMARY

REVIEW OF THE CARE AND TREATMENT OF
RO102018
DATE OF BIRTH 09 11 1989
DATE OF DEATH 23 08 2017

EXECUTIVE SUMMARY

This review was commissioned by the Falkland Islands Government and sought to examine the circumstances and events leading up to the death of RO102018.

Principally it aimed to recognise good practice and identify areas for improvement.

The review process was comprehensive and included face to face interviews with key members of staff and family as well as examination of the detailed chronology of events and available case records.

The review team consisted of independent, experienced clinicians with a background in health improvement, Dr David J Hall and Mr Johnathan MacLennan who both have roles with NHS Scotland and Healthcare Improvement Scotland. This review was conducted by them independently from their roles within NHS Scotland.

BACKGROUND AND SUMMARY

RO102018 had a history of mental health problems going back a number of years. She was an in- patient at the time of her tragic death.

She was being managed in a general ward with psychiatric input from a psychiatrist based in the UK and on-island expertise available from the CPN team. Her day to day care was provided by the nursing staff on the ward led by the Chief Nursing Officer and the Ward Manager and with input from the Medical Officers covering the ward. She was not detained on compulsory measures at the time of her in-patient stay or death although consideration had been made regarding this.

FINDINGS AND RECOMMENDATION

The need to avoid where possible lengthy in-patient stays in the management of an individual with her complex difficulties is recognised as current best practice. Patterns of escalating risk-taking behaviour whilst an in-patient in such individuals is often seen and an attempt to move her care beyond Hospital is in keeping with recognised current best practice.

Overall the care and treatment being provided for RO102018 was appropriate for the management of someone with the complex difficulties that she presented with. In keeping with the agreed remit of the review the family were asked for and have detailed their concerns and issues in section 9 of this document.

1.1 CARE AND TREATMENT

1.2 The overall care and treatment being provided for RO102018 was appropriate. The management of an individual with her complex difficulties is undoubtedly challenging. This is particularly so in a non-specialist setting with a relative lack of direct access to specialist help. Elements of good practice were present including evidence of day to day goal setting and inclusive multi-disciplinary planning meetings.

1.3 The care was overseen by the supervising Consultant Psychiatrist remotely and was being directed on a day to day basis by in-patient staff. There was however a clear lack of clarity around who was providing day to day clinical leadership and how specialist on-island expertise was being made available. The CPNs did contribute to her ongoing care whilst on the ward, but this was not in a clearly defined and agreed way but was rather more ad hoc.

1.4 There was a lack of clear structure around the development and recording of mental health progress with the absence of any specific care plan detailing how her care should be structured for her mental health problems.

1.5 Furthermore, although the locally used risk assessment tool (which the reviewers felt was an appropriate proforma) was completed, ongoing risk management was not informed by this as it was not effectively utilised or updated.

1.6 The standards of record keeping overall were acceptable and utilised the usual local system but did not have the structure and clarity that would have existed were there a specific care plan or care pathway to follow.

RECOMMENDATION 1:
A CARE PATHWAY SHOULD BE DEVELOPED FOR ALL MENTAL HEALTH ADMISSIONS

The pathway should identify:
1a] Timeous and [standardised] evidence-based risk assessment completion and review. There should be a clear timeline and clear detail of responsibilities for who updates and when and what actions should be taken as a result of change.
1b] Care plan development and review that addresses all aspects of the individual's presentation. This and the risk assessment should include, where appropriate, patient and carer views – this should be an integral theme throughout the pathway.
1c] The care pathway identifies responsibilities of specialist mental health staff, the admitting doctor, the ward nursing staff and the level and nature of involvement of the supervising Consultant.
1d] The structure and frequency of planning meetings post-admission and pre-discharge as well as at other points should be clarified.
1e] The pathway will have a recognised tool for carer/family/next of kin engagement and how their contribution, where appropriate, can enhance delivery of care.
1f] The pathway will identify appropriate medicines management including reconciliation at admission and structured, regular medication reviews. Patient views to medication and side effects should be included in this.

1g] In addition the pathway should be developed locally to include specific plans for periods off the ward (for detained and voluntary patients), a crisis plan and plans for addressing high risk behaviour including absconding or alcohol misuse.
1h] The potential for developing a Mental Health Improvement Group or Collaborative to develop the local mental health pathway should be explored.

2.0 WARD ENVIRONMENT

2.1 The ward is a standard medical facility with no specific provision for patients with mental health problems.

2.2 Our impression, having visited the ward on a number of occasions, was that the overall feel is to be commended.

2.3 However, given it is a general ward with no adjustments to accommodate mental health and challenging behaviour, we feel that creating a therapeutic space for mental health patients with attention to as many safety issues as practicable would be of benefit.

2.4 We did not feel that the ward environment was a specific factor in RO102018's death however.

RECOMMENDATION 2:
A SAFE, THERAPEUTIC SPACE SHOULD BE AVAILABLE FOR ALL INPATIENT MENTAL HEALTH ADMISSIONS

2a] The plans to modify an area within the ward be as "safe" as practicable but also to be therapeutic and to meet the needs of individuals with mental health problems should be developed following best available evidence.

2b] In addition to a therapeutic environment, the provision of a timetable of activities and engagement to enhance the use of any space is to be recommended.

3.0 STAFF TRAINING AND EXPERTISE

3.1 We were impressed by the dedication and efforts of staff, particularly of nursing staff and also of unregistered staff, in terms of their wish to do their best by any mental health patient and by RO102018 specifically. It was clear however that the level of confidence in dealing with difficult behaviours such as RO102018 at times demonstrated, was very variable. The expertise within the CPN team is excellent but again there is a lack of clarity as to how much input the in-patient staff should expect from the CPNs.

3.2 Amongst medical staff the Chief Medical Officer showed an appropriate level of understanding and commitment to managing RO102018 and others with mental health problems, but our impression was that there was otherwise a lack of specific interest in mental health matters amongst the medical officers. Most have undergone some training in the Mental Health Ordinance, but it is important that there is a broader appreciation of the need for mental health awareness and training across all staff groups including nursing and medical staff.

3.3 The role of the carers was from our discussions a compassionate one but we felt that more effective use of this important resource, i.e. the carer's input with patients, should be developed.

RECOMMENDATION 3:
TRAINING FOR ALL CARE STAFF IS PARAMOUNT BUT MUST BE MEANINGFUL AND APPROPRIATE

3a] A training needs analysis should be carried out to establish the scope and scale of training required for staff at all levels. We would suggest that this should be done as a quick and brief overview to inform the development of a training plan.

3b] We would anticipate that as a minimum all staff [including the carers] should receive mental health first aid and STORM/Suicide Awareness Training. There is a level of prevention of violence and management and aggression training already in place which can be built upon.

3c] In our discussions with the various staff groups we found there was an appetite for the development of a local mental health forum. This, along with a clear training plan would ensure that skills were developed, reinforced and refreshed.

4.0 THE CARER'S ROLE

4.1 We were impressed by the compassion, skills and understanding exhibited by many of the carers that we spoke with.

4.2 We however found that it was variable as to how included they had been in any handovers of information to inform RO102018's ongoing care.

4.3 We feel that it was a missed opportunity to include their reflections and observations in the day to day care planning for RO102018 or for any patients with whom they would have input.

RECOMMENDATION 4:
THE ROLE OF UNREGISTERED STAFF SHOULD BE DEVELOPED TO SUPPORT MENTAL HEALTH CARE AND TREATMENT

4a] All staff, including unregistered staff, involved in the care of mental health patients, should be included in the collection, recording and communication of information regarding the patient in their care.

4b] Handovers or "huddles" should include all staff present to allow input from all staff including non-trained staff to assist day to day care planning for mental health/psychiatric in-patients.

4c] Broad consideration should be given to the development of the role and the support for carers within that role.

5.0 THE OVERALL CONFIGURATION OF MENTAL HEALTH SERVICES

5.1 For the population of the Falklands the provision of three CPNs is reasonable, one must take into account the fact that they are carrying out roles which in other services would be provided by counsellors or trained clinical psychologists.

5.2 There is a broad degree of expertise and skill within the CPNs, but the focus of the on-island mental health expertise needs to include sufficient dedicated resource towards the more acutely unwell individuals – particularly those who require in-patient care.

RECOMMENDATION 5:
HOW MENTAL HEALTH ADMISSIONS ARE SUPPORTED BY SPECIALIST MENTAL HEALTH PRACTITIONERS IS A PRIORITY DEVELOPMENT AREA

5a] We do not feel that an overall review of the mental health service is required, but we do feel that a local high-level review by the management team of caseload management and current practice is undertaken with a view to safeguarding an appropriate level of resource specifically for those presenting acutely and particularly those who require to be managed in the hospital.

5b] Agreement as to how much CPN time should be spent supporting in-patient staff and inputting to the management of in-patients has to be agreed for the future. We note that there has been a change in practice already for a current mental health in-patient during our time on the Island and we are pleased to note that the service has already started to reflect on this need.

5c] Additionally, access to out of hours or weekend specialist mental health input is required. We understand that discussion has taken place regarding buying in to a remote on call service for specialist advice – primarily Consultant Psychiatrists. We would recommend that this is pursued.

5d] In addition, agreement as to the level of access to the on-island expertise within the CPNs is required. We understand again that the current situation has already changed and that CPNs are making themselves available when there is an in-patient on the ward in the out of hours or weekend period. Again, we feel that this should be further reviewed and change implemented.

6.0 MENTAL HEALTH SERVICES

6.1 We heard concerns through a number of our interviews and read in the Coroner's Report that mental health may be a "Cinderella service" (the term was used by a number of individuals) in that no level of priority was given to the same.

6.2 We observed that within the management structure it is not entirely clear who champions the cause of mental health services or developments at a strategic level.

RECOMMENDATION 6
A STRATEGIC, CONSISTENT, BALANCED VOICE FOR MENTAL HEALTH IN THE FALKLAND ISLANDS IS REQUIRED:

6a] We recommend that the Falkland Islands Government should reflect as to who at a strategic level should champion mental health issues.

6b] The broader requirements of promoting mental health awareness and suicide prevention would support the option of a public health remit and should reflect as to who at a strategic level should champion mental health issues. We would recommend that consideration be given to the development of an overall mental health strategy covering both service delivery and public health pertinent to mental health.

We have been made aware since our time on the Island that there was a strategy developed in 2006 but given the time since this (without review) and the circumstances leading to the production of this report, timing for a new mental health strategy presents as ideal.

7.0 IMPACT

7.1 It was very apparent to us as to the huge impact which RO102018's death has had on the community as a whole and the focus on mental health issues and suicide which this tragic event has precipitated. We were made aware of the immediate support that was available after RO102018's death and this was commendable however this was time limited and not accessible by all concerned parties.

RECOMMENDATION 7:
A PROACTIVE STRATEGY SHOULD BE EXPLORED TO IDENTIFY HOW MENTAL HEALTH IS SEEN AS A PUBLIC HEALTH ISSUE:

7a] We recommend that consideration be given as part of a mental health strategy, to identify broader work around mental health and suicide awareness, particularly looking at how younger people can and are engaged with potential supports and services before problems escalate.

7b] We had a productive meeting with a representative from "Team Tranquil" and were pleased to note that such an organisation exists on the Island and should be key partners in the development of a broader strategy around mental health matters including the public health aspects.

8.0 PROCESS FOLLOWING A SIGNIFICANT ADVERSE EVENT

8.1 It was made clear to us that there had been no pre-existing clear process to support, inform and include staff and more particularly relatives, following a significant adverse event. We were aware of commendable efforts to offer support via the creation of a dedicated mobile phone helpline, sessions for staff and support in the immediate aftermath for the family when visiting.

8.2 Similarly there was no pre-existing clear process of review with timescales, terms of reference and clear indications of staff and relative involvement in place. The relatives felt

particularly unclear about what the next steps would be in terms of more formal review of RO102018's death and how this would be carried out and what their input would be. Furthermore, nor are there any clear process of review with timescales, terms of reference and clear indication of staff and relative involvement.

RECOMMENDATION 8:
A CLEAR PROCESS SHOULD BE PUT IN PLACE FOLLOWING ANY SIGNIFICANT ADVERSE EVENT FOR SUPPORTING STAFF AND PATIENTS

8a] A clear process and timescale for reviews, their scope and the manner in which reviews will be conducted should also be put in place.

8b] This should also include a clear description of how any lessons learned will be communicated and implemented and consideration of a process to learn from "near misses" for instance which potentially result in harm.

9.0 SPECIFIC ADDITIONAL ISSUES RAISED BY THE FAMILY –
As detailed in the introductory summary the family had concerns which were raised with the reviewers and are detailed in this section.

9.1 CONCERNS REGARDING LACK OF CLARITY AROUND THE REVIEW PROCESS
9.1.1 This has been considered under point number 8 and recommendation number 8 that there should indeed be a clear process and timescale for reviews with specific reference to relatives' involvement.

9.2 CONCERNS RE POTENTIAL LACK OF RESOURCES IMPACTING UPON RO102018'S CARE
9.2.1 We did not find RO102018's care was influenced by a lack of resources however as highlighted in our recommendations above, we felt that there was a lack of clarity around how the available specialist expertise was regularly and systematically included in managing and planning her care.

9.2.2 Similarly the arrangement for the oversight by the remote psychiatrist was appropriate but lacked a 24/7 element and any clear holiday/planned or unplanned absence or out of hours coverage.

9.2.3 As indicated in recommendations 1 and 5, we feel that there should be a consideration of how the available expertise and resource is organised to ensure that a dedicated element is available in a consistent way when individuals require more intensive in-patient care.

9.3 CONCERN AS TO WHETHER THE MENTAL HEALTH ORDINANCE SHOULD HAVE BEEN USED IN RO102018's CASE
9.3.1 We considered this carefully and discussed with all appropriate staff members. We were also able to see the Ordinance and the Code of Practice and note that the principle of 'the least restrictive alternative' applies. Therefore, in common with practice in the UK, if a person can be treated voluntarily, then that is seen as preferable and for much of

stay she was willing to accept the care, indeed at times sought out care on a voluntary basis. The fact that at points of crisis it was considered that she might become "detainable" is again not contradictory and is in keeping with best practice in other areas.

9.3.2 We note that RO102018 agreed to a 'contract' regarding her behaviour on the ward which included conditions pertaining to her access to her mobile phone and other 'privileges'. We are mindful of the need to consider basic human rights in drawing up such contracts or agreements with non-detained patients particularly.

9.3.3 Overall, we did not feel that the Mental Health Ordinance did require to be used and nor did we feel that had it been used it would have had any significant impact on the care that was being delivered to her.

9.4 CONCERNS RE THE DECISIONS BEING MADE REGARDING RO102018's EMPLOYMENT AND THE INVOLVEMENT OF POLICE

9.4.1 We explored as much as was possible within the time constraints the process that was followed and the decision to terminate RO102018's employment and to involve the police. We were reassured that the clinical team had been involved in discussions about how these decisions were communicated with RO102018 but there was no suggestion that the clinical team was asked to input to the decision as to whether or not she should lose her job. They were asked regarding her fitness to be interviewed by the police regarding the alleged crime.

9.4.2 It was clear that the decision to terminate her employment was made by senior hospital managers in conjunction with human resources. There was no involvement with the occupational health service, and although we were told this was because there was an awareness that RO102018 was having support from the mental health service, it would seem to have been a missed opportunity to involve occupational health at an earlier stage as would normally be the case with any employee with health problems.

9.4.3 It is beyond our remit to make detailed comment on whether or not a particular process should have been followed in terminating her employment but again we would re-state that we are reassured that the clinical team was fully involved in discussions about how best to communicate this news to her. Ultimately the fact that she knew that she was very likely to lose her job pushed the team towards agreeing to give her the news at a point when she was still in Hospital. Ultimately, recognising our remit, we express no view as to whether the decisions, in relation to her employment and to involve the Police, were themselves appropriate. However, we can comment that it is recognised good practice to ensure that patients with conditions similar to those detailed in this review are appropriately held to account for their actions.

9.4.4 Similarly the decision regarding involving the police was not one which was made by the clinical team although they were asked to advise regarding how best to involve the police and she was supported in her interview with them.

9.5 CONCERN RE THE SUITABILITY OF THE PHYSICAL ENVIRONMENT IN WHICH SHE WAS NURSED

9.5.1 We do not feel that the environment was specifically a factor in RO102018's death but as indicated in recommendation 2, we do believe there is a case for making some modifications to the environment to make a therapeutic and safer space for individuals with mental health problems to be managed.

9.5.2 We were pleased to note that this work has now been agreed and, as we have recommended, the best evidence in design and layout of the available space should be followed.

10.0 RESPONSE TO THE REPORT FROM RO102018'S PARENTS

10.1 The standard process which we have followed seeks to include the views of the family throughout the process of review.

10.2 The family – RO102018's parents in this case, have taken time to meet with us and to consider
our reports and our recommendations and have made a number of specific points.

10.3 We note that they agree with our recommendations but have highlighted a number of particular areas of concern.

10.4 These particular areas of concern include the lack of clarity and lack of engagement in any discussions regarding the process of review.

10.5 Additionally the family have expressed considerable concern regarding the decision making and processes followed with regard to RO102018's employment and the involvement of the police.

10.6 We have attempted to ensure that our recommendations included a balance of what we heard from all sides but do reflect the concerns of those most directly affected.

DR DAVID J HALL
Consultant Psychiatrist/Deputy Medical Director NHS Dumfries & Galloway and National Clinical Lead for the Scottish Patient Safety Programme

JOHNATHAN MacLENNAN
RNMH, Improvement Advisor and Lead for the Scottish Patient Safety Programme Mental Health

Action Plan following Significant Adverse Event Review – Mental Health

Progress/Indicator RAG Status	
	Work is significantly behind schedule and no progress has been made and/or progress has been made but the timescale has not been achieved
	Progress is being made, progress is good and the action is likely to be achieved within timescale. Or the action has been completed but evidence is required to demonstrate achievement.
	The action has been completed and there is a record of evidence to support its completion

Recommendation Number	Specific Action	Success Indicators & Expected Outcomes	Achievements to Date	Potential Barriers to Success	Lead	RAG Rating	Completion Date
As identified in the original report	*Indicate the actions or series of actions to be taken to achieve expected outcome. They must be SMART.* *Examples might be deliver training, develop new policy, introduce new standards, review working practices etc.*	*Describe the evidence you will provide and what improvements/changes to practice etc. that will be expected.* *These might be new policy, training attendance records etc.*	*Indicate what actions which have been already undertaken or provide evidence that this work has been achieved.*	*Describe what possible obstacles which may prevent you achieving success.* *These might be financial, political, technological etc.*	*Identify the lead person who will be accountable for completing the action.*		*Date by which actions will be completed.* *On completion, list supporting evidence*
1. Development of Care Pathway for all mental health admissions to include:							
1a – Evidenced based standardised risk assessment	Produce a standardised Risk assessment tool Accessing further advice from Scottish patient safety programme	Risk assessments undertaken at regular intervals using a standardised, systematic approach. Risks are identified and Actions to prevent or reduce potential harm put in place. Accessing further advice from Scottish patient	A number of tools have been considered. Selected tools have been discussed and are being refined to make they more 'user friendly' e.g. size of text boxes. Trial for 3/12 and then review December. CPNs are putting summary of their current assessment on EMIS	Staff may lack confidence in undertaking Risk Assessment without prior training. Risk assessment tool not completed due to lack of training	SCPN – in consultation with ward manager / Staff involved in undertaking risk assessment		*Sept 2018 Trial of tools, to be reviewed in December 2018*

		safety programme					
1b – Care Plan development	Review and up-date current documents	A comprehensive standardised single shared computerised Care Pathway for all to use – which can be titrated to individual patient needs. Care Plan which is accessible to all including Nursing/Medical staff and allied Health Professionals to Assess, Plan, Implement, Evaluate and Review care at regular intervals. Staff competent in completing Care Plans and there is clear evidence of decisions made and treatment planning Information across Medical, Nursing and AHP records	Care Plans in place but require reviewing Including actions, risks and safety. KR and RE discussing with J MacL on 24/09/2018 KR and JD are planning visits to acute inpatient facilities in November 2018 when updating de-escalation training. PEP (psychiatric Emergency Plan will be developed to compliment the Inpatient policy / TMV policy). The Admission / Assessment Suite will be needed for this. During acute admissions to the ward the ward based hard copy care plans in use. Longer term planning on CPN care plans.	Insufficient man-power to provide both clinical and administrative duties. Lack of a Computerised system across all services Staff may lack experience in using computerised systems which all staff are competent to use	CPNs		*Jan 2019*
1c – Responsibilities of all health professionals (also cross ref with Rec 5c regarding 27/4 external support)	Review of Job descriptions. Nursing, and Allied Health Professionals involved in care of mentally unwell patients psychiatric emergencies and care of patients with complex co-morbidity including mental illness. Identify Core competencies Comprehensive induction	Roles and responsibilities identified and included in JD. Through regular performance management – review and revise JD to reflect changing trends and developments Structured line management making and clear communication links	CNO in the process of reviewing JD as part of Nursing Strategy All consultations including remote followed up with written report – proforma to be developed for consistency. Candidates now able to apply 'on line' and the possibility of being able to use the NHS Jobs website for recruiting is being explored.	Staff recruitment and retention	CNO		*Jan 2019*

1d – Structure and frequency of MDT meetings	Develop TORs – which identify Chair Person and members. To include admin support in order to document the decisions made and actions to take.	Regular standardised meetings to plan, review and evaluate care – documented evidence of decision making process	The 'Child Death' protocol is being used as a model to develop this work. The initial draft is being prepared in October and there will be an 'Away day' for this initial draft to be discussed and refined in late November 2018 / Early December 2018. The intention is for the CMO to take time away from clinical work to achieve this. The plan is to have the document being trialled by the end of 2018	Staff availability due to other commitments	CMO/SCPN		*Oct 2018* *For development of initial draft* *November / December 2018 for 'away day'* *December 2018 live document*
1e – A recognised tool for Carer/Family/NoK engagement	Accessing further advice from Scottish patient safety programme	Staff familiar with documents available for mental health admissions. Ensure that the patient's needs are met and the sharing (or not) of information and to whom, is clearly documented, including reasons why this is not achieved. Family involved in treatment and care decisions if patient consents.	Already included in admission documentation Review and revision of current documentation to reflect consent and engagement. E.g. consolidation of three carer forms into one. Consideration of additional document (e.g. Triangle of Care Consent is highlighted in CPN safety plan as well as in the risk assessment document.	Patients who do not give consent for family involvement/engagement	SCPN		*Sept 2018*
1f – Medicine Management	Work in progress to review Psychiatric Formulary	Revised formulary in place Clear guidance regarding medication available and indications for use	Already included in admission documentation A draft formulary has been developed by the visiting psychiatrist and is now being finalised with the KEMH pharmacist CMO and CPNs		Visiting PSYC CMO Pharmacist SCPN		*October 2018*

1g – Specific plans for periods off the ward including absconding	Plans already in place	Revise plan to include action to be taken if patient absconds Clear guidance available to all staff on how to inform key staff (both internally and externally) and escalation process if patient absconds When patient requiring this is admitted check appropriate process is in place.	Plans already in place – i.e. individual care plans are drawn up on admission and amended as needed - part of this will include what to do if patient absconds/takes an OD/becomes violent etc.etc. depending on that patient's particular risk. **To be reviewed case by case** To include patient in planning as far as possible –not 'nanny state'		SCPN/Ward Manager		*Sept 2018*
1h – Develop a Mental Health Improvement Group to develop the local mental health pathway	Identify Key staff involvement in Safeguarding - Mental health strategy	Group have regular meetings to develop and review pathway. Clear line of communication with other groups to share information This working group would constantly champion mental health and wellbeing across the Islands and across all agencies, FIG (Inc. OH), private, Mod, incoming companies etc. Inclusion of training plan	DHSS and DP have met to discuss. Agreed that a representative from the Public Health Strategy Steering Group will be essential. Possible membership also to include: CMO, SCPN, CNO, Representative from Education a service user (if a service user can't be identified a community representative) and a representative from the MoD to reflect the island wide nature of this work. Explore best way of service user feedback; consider 'advertising' if anyone who has had experience of our MH services as a service user, family member or friend who would be willing to share their experience and thoughts about the service contact us and have the option of individual discussions or small focus groups depending on their preference. These are initial thoughts and examples of how other organisations, such as MIND.	Lack of training for volunteers – Team Tranquil in their capacity of an independent advisor. Encouraging Public involvement	CMO/DHSS		*Jan 2019*

2. A safe, therapeutic space should be available for all mental health admissions to include:							
2a – An area within the ward be as 'safe' and therapeutic to meet the needs of individuals	Name change to 'Admission Suite' suitable for any patient with extra needs	Multi-purpose room to care for patients with additional requirements	DHSS has discussed at CMT project board. Identified that this is a standalone project and NOT to be rolled into the wider KEMH redevelopment phase one project to avoid unnecessary delays. Quotation for work received – As the quotation was over the tender threshold dispensation from the tendering process was requested however this was not granted and so the tender process is in progress. Building permit has been issued, which is subject to fire compartmentation work being completed as part of the work (this work was included in the quotation received)		SCPN/Ward Manager/ Estates Manager		Tender issued 10th Sept 2018. Submission deadline 9th Nov 2018 Tender board scheduled for 15th Nov
2b – Provision of a timetable of activities and engagement	Clear information on range of activities available	Identification of possible actives and who will be providing them. Identification of who will be providing/overseeing activities – carers/volunteers and clarification that they have received appropriate training	Inpatients with mental health needs are already encouraged to work with staff to develop their activity timetables and follow them, however there is still some work to be done in this area. e.g. to review information of what is / can be available There is not enough need to have set 'time table' in place and people's needs may differ – time tables need to be person specific Explore opportunities for closer engagement with leisure centre Needs to be devised with / by the patient as much as possible		SCPN/Ward Manager		*October 2018*

3. Training for all care staff – meaningful and appropriate							
3a – Training needs analysis to be carried out		Care staff will have the appropriate knowledge and skills and meet required competencies	Additional training for 1:2:1 carers planned (info from MH) Use of appraisal system for permanent staff which includes a section on development for each person. This process is staff lead and so they will be working with their managers to identify their individual needs. This information can be used to inform this area. Meeting between DHSS and College Manager to discuss training opportunities (including Mental Health First Aid and TRiM). Possibilities for provision of these courses being made available via the training centre are being explored further. SCPN intending to attend the next Mental Health First Aid course at MPC to experience the course and consider the suitability of using it. Plans in place for STORM training at differing levels CPN attending APEX training in January 2019 to identify if this would be an appropriate training for some of our staff.	Availability of appropriate trainers to provide courses.	DHSS/Training centre		December 2018
3b – All staff should receive mental health first aid and STORM/Suicide Awareness Training		Competent staff to provide care and treatment	STORM training planned for April 2019. Levels 1 – 3 ranging from 2hr information sessions (general audience) to 2 day course for hands on clinical staff. The two weeks will give local trained staff and also trained trainers who will	Training budget constraints Experienced Staff to deliver training Staff availability to attend training	SCPN / CMO		STORM training April 2019

			be able to continue with training for new staff and refreshing others as necessary. Requested finance was approved in 2018/2019 budget APEX course being considered. CPN booked to attend CMO to attend a course if it can be arranged and then suitability will be considered				
4. Role of Unregistered staff should be developed to support mental healthcare and treatment							
4a – All staff involved in the care of mental health patients should be included in the collection, recording and communication of information	Develop multi agency care plans which are accessible to all health professionals.	Staff are fully informed and included in the decision making process Comprehensive records kept which relevant staff have access to in order to provide person centred care	Comprehensive records kept which relevant staff have access to in order to provide person centred care 1:2:1 carers attend 2pm handover and other handovers if available. Information recorded by 1:2:1 carers now to be incorporated into the patient's notes (spot check needed to confirm)	Staff access to computers Lack of computer skills currently using paper notes, but need to ensure *all* staff are confident to use computers when ward notes become electronic.	WM		In place, but will need to revisit when the clinical information system changes.
4b – Handovers or 'huddles' should include all staff involved to allow input	Involvement in ward round and handover between shifts	Staff are fully informed and included in the decision making process	As above		CNO CMO WM		As above
4c – Broad consideration should be given to the development of the role and the support for carers	Review of Job Descriptions	Provide High field training opportunities. Comprehensive Mandatory training programme	As 1c		CNO WM		Linked with 1c Jan 2019
5. Mental health admissions are supported by specialist mental health practitioners							
5a – High level review of caseload management and current practice is undertaken	Identify lead for the overall care of patient	Staff have access to appropriate specialist advice 24/7/365	Provision of 24/7 remote support by UK psychiatrists has been discussed and confirmed, including who will be available, what level of staff is appropriate to contact them. Clear information regarding this to be understood by all staff needing	Lack of consultant cover 24/7 specialist advice	CMO		Arrangement in place Sept 2018 Information to be in place October 2018 to ensure this information is

			this information. The system will be reviewed at the end of 2018 to ensure the use of the emergency out of hours support has been appropriate and also that the correct level of staff are making the referrals. The audit will review the perceived need for out of hours mental health service contact for advice/ or consultation and advice.				consolidated
5b- Agree as to how much CPN time is allocated to support in-patients and staff	Rota system to identify CPN involvement in ward rounds – Monday/Friday and handover Friday pm – to ward and DR -	To improve communication and sharing of information Provide staff with support and advice. Planned days/times when staff are accessible and available	Implemented – CPN Attends daily ward round and weekly rota in place	Staff availability Insufficient man-power to provide both clinical and administrative duties.	Community Mental Health Team		In place
5c – Access to out of hours or weekend specialist mental health input is required	Clarity of specific roles for GPs /on call doctor/CPN/ consultant psychiatrist to be determined. Key stakeholders (emergency service, social services and patients) involvement	To be included in overall mental health strategy	Linked with remote support (5a) Audit in progress with A&E, GPs, Ward OOH identifying when they may have wanted additional MH input if available	Lack of clarity regarding key competencies required by GPs and CPN Which can be exacerbated by high turn-over of staff and staffing pressures.	DHSS/CMO		Jan 2019
5d – Agreement as to the level of access to the on-island CPN expertise	To be included in overall strategy				DHSS/CMO		Linked to Strategy
6. A strategic, consistent, balanced voice for mental health in the Falkland Islands is required							
6a – FIG should reflect as to who at strategic level should champion mental health issues	DHSS in consultation with Public Health to determine champion and way forward	FIG to recognise Mental Health Issues CMT quarterly up-dates across directorates – eg emergency services, HR,	DHSS inputs to CEO, CMT and HMIC Health and Social Services Portfolio holder to be kept up to date regarding Mental Health	Political and financial constraints	CMO/DHSS		*Ongoing*

		PWD, Education	matters				
6b – Development of an overall mental health strategy covering both service delivery and public health	a/a	Robust and user friendly strategy in place, understood and in use.	Firstly current Mental Health Strategy being reviewed to provide working document while development work progresses. 'Health in Mind Mental Health Survey' in progress, initial findings expected January 2019 Following initial findings of survey community participation through community groups and involvement of stakeholders and 'Team Tranquil' Development of draft strategy followed by another round of consultation before strategy published. (Backfill for SCPN will be required for the latter part of this work. ExCo paper will request this and the SCPN will identify at what point this backfill will be required)		SCPN/CMO/ DHSS		*Initial Survey findings January 2019* *Additional mile stone dates to be added*
7. A proactive strategy should be explored to identify how mental health is seen as a public health issue							
7a – As part of the mental health strategy, to identify broader work around mental health and suicide awareness	Mental Health Survey already undertaken.	Final results of this survey to be included in the overall Strategy Results from the Mental Health Survey.	Independent Mental Health Survey completed	Staff availability and time constrains to complete this work.	SCPN/DHSS		Work in progress
8. A clear process be put in place following any significant adverse event for supporting staff and patients and Families							
8 – A clear process and timescales for reviews (this also links with 1d)	Produce a flow diagram which includes contact details of key staff, how and when they can be contacted. Provide details of planned time scales for reviews	Clear processes in place which provide guidance in order to have a consistent approach following adverse events Structured system in place to review and	Developing safeguarding adults board Bill to include the commissioning of independent reviews which will give a standardised approach for response to adverse events with regard to adults.	Lack of training in Root Cause Analysis	DHSS/AG/ DP/ CNO/CMO		Safeguarding adults Bill scheduled to go to ExCo in October 2018. Further work to follow.

	and discussions Access further advice from Scottish patient safety programme clear description of how any lessons learned will be communicated and implemented including providing staff and patients with timely information regarding outcomes, lessons learned and any changes to practice	investigate any un-planned or unexpected event	Wider work to develop a standardised approach to adverse events across FIG requires further discussion with Policy and AGs office				
Draft action plan to discuss recommendations from Significant Adverse Event Review Mental Health April 2018 *1st meeting 04/05/2018 in attendance Mandy Whittingham, Director, Dr Rebecca Edwards, Chief Medical Officer, Mandy Heathman, Chief Nursing Officer, Janice Dent, Ward Manager, Carole Coombs, Community Psychiatric Nurse, Karen Rimicans, Senior Community Psychiatric Nurse, Janette Vincent, Healthcare Governance Manager.* *2nd meeting held on 28/05/2018 same attendance as above*							