NHS Resolution

PRESS STATEMENT

07 September 2018

Embargoed until 00:01am Monday 10 September 2018

NHS Resolution reviews suicide-related claims to help prevent future harm

NHS Resolution is calling for improvements and better integration across the NHS and mental health services to ensure at risk patients are given more support and care having carried out a thematic review of suicide-related claims.

The report, launched to coincide with World Suicide Prevention Day on 10 September 2018, *Learning from suicide-related claims: a thematic review of NHS Resolution data*, examines some of the factors that contribute to suicide claims and the quality of investigations following these tragic incidents.

101 deaths occurring between 2010 and 2017 were examined in-detail. The NHS trusts involved in these cases were supported through NHS Resolution's inquest scheme[1]. In addition 25 claims relating to non-fatal suicide attempts were also analysed for comparison.

To reduce the risk of suicide-related incidents and to improve the response of trusts, NHS Resolution has made nine recommendations for NHS trusts and national bodies. The recommendations highlight potential learning for those delivering mental health services in England. Where recommendations explicitly reference bodies external to NHS Resolution, we have worked with them to agree the relevant recommendation and are grateful for their support and commitment to action them.

Working in partnership with organisations including the Royal College of Psychiatrists, NHS England, NHS Improvement, Her Majesty's Prison and Probation Service, and families and staff

members affected by suicide, the study draws on the unique dataset held by NHS Resolution to explore best practice and key areas such as:

- the shared clinical characteristics of those ending their lives by suicide that result in a claim for compensation; and
- how well families, carers and staff are supported following suicide; and
- the investigation process.

Psychiatry/mental health claims represented 320 (3%) of clinical claims by number in 2017/18, and accounted for just 2% of the total value of new claims reported. However, these cases are devastating for all involved: individuals, their families and carers and often the NHS staff that are involved in their care.

Dr Alice Oates, NHS Resolution's Clinical Fellow and author of the report says: "Sadly many of the clinical findings in this report will be familiar to those working in mental health. We found that, generally there was poor support for those with substance misuse problems, inadequate communication with patients and families, and a lack of a range of services to support individuals. The quality of risk assessments, therapeutic observation and subsequent serious incident investigations conducted by some trusts needs improvement. Finally, following a death, the support offered to both families and staff involved was variable."

"That said, we must not lose sight of the good, innovative practice occurring across the country. By learning from good practice and from where things can be improved, I hope this report and the associated recommendations will help trusts to improve their suicide prevention work and in turn support safer patient care and better support for families and staff."

The UK National Representative for the International Association for Suicide Prevention, founders of World Suicide Prevention Day, says: "This report highlights important lessons we can learn from claims for compensation following the death of a loved one by suicide. It not only offers insight, but also guidance through recommendations and examples of good practice to help implement change. Service providers, in particular, will find this a valuable resource."

Helen Vernon, Chief Executive of NHS Resolution says: "This work reflects our renewed commitment, outlined in *Delivering fair resolution and learning from harm: our strategy to 2022*,

to learn from inquests, share learning from harm and work in partnership with others to drive forward the patient safety agenda, in this instance with a focus on mental health."

The full recommendations are:

1). A referral to specialist substance misuse services should be considered for all individuals presenting to either mental health or acute services with an active diagnosis of substance misuse. If referral is decided against, reasons for this should be documented clearly.

2). There needs to be a systemic and systematic approach to communication, which ensures that important information regarding an individual is shared with appropriate parties, in order to best support that individual. Trust boards should consider how communication is best enabled within their existing systems and prepare to adapt to new models of care, which should include working models to facilitate communication across services.

3). Risk assessment should not occur in isolation – it should always occur as part of a wider needs assessment of individual wellbeing. Risk assessment training should enable high quality clinical assessments, which include input from the individual being assessed, the wider multi-disciplinary team and any involved families or carers. While acknowledging that risk can be considered as 'high', trusts should move away from stratifying risk assessments into crude 'cut offs' of risk, and encourage more descriptive formulations of risk. In order to ensure that professionals are performing to a high level, this training should be regularly during clinical supervision.

4). The head of nursing in every mental health trust should ensure that all staff including:
- mental health nursing staff (including bank staff and student nurses who may be attached to the ward);
- health care assistants who may be required to complete observations; and
- medical staff who may 'prescribe' observation levels

undergo specific training in therapeutic observation when they are inducted into a trust or changing wards. Staff should not be assigned the job of conducting observations on a ward or as an escort until they have been assessed on that ward as being competent in this skill. Agency staff should not be expected to complete observations unless they have completed this training.

5). NHS Resolution should continue to support both local and national strategies for learning from deaths in custody. In particular, there should be ongoing work to review learning from litigation in cases involving prison healthcare, which will continue to inform the Prison Safety Programme and National Partnership Agreement action plan. External bodies such as Her Majesty's Inspectorate of Prisons (HMIP) and the Care Quality Commission (CQC) have a role to play in sharing good practice nationally, and will ensure that the aforementioned programs are effective in delivering their objectives.

6). The Department of Health and Social Care should discuss work with the Healthcare Safety Investigation Branch (HSIB), NHS Improvement, Health Education England and others to consider creating a standardised and accredited training programme for all staff conducting SI investigations. This should focus on improving the competency of investigators and reduce variation in how investigations are conducted.

7). Family members and carers offer invaluable insight into the care their loved ones have received. Commissioners should take responsibility for ensuring that this is included in all serious incident (SI) investigations by not 'closing' any SI investigations unless the family or carers have been actively involved throughout the investigation process.

8). Trust boards should ensure that those involved in arranging inquests for staff have an awareness of the impact inquests and investigations can have on individuals and teams. Every trust should provide written information to staff at the outset of an investigation following a death, including information about the inquest process. In addition we recommend that the following mechanisms to support staff are considered:

- The SI investigator should keep staff members up to date with the SI process, and the trust legal team should inform them of whether they will be called to coroner's court as soon as this information is known.
- There should be formal follow-up points to 'check in' with staff that have been involved in an SI. For example, there could be a follow-up meeting with managers three months, six months, and one year after the SI to ensure staff are supported both throughout the process and when it has finished.

- Introduce a system for monitoring and alerting managers when staff have been involved in more than one SI in close succession in order to highlight the potential need for additional pastoral support.

9). NHS Resolution supports the stated wish of the Chief Coroner to address the inconsistencies of the PFD (report to prevent future death) process nationally. We recommend that this should include training for all coroners around the PFD process. Monitoring of the PFDs given, both in terms number and content should lie with both the CQC and other external bodies, with this information being shared nationally to drive improvement in health care systems.

Ends

Notes to editors

1. The Inquest Scheme: Since 1 April 2013, NHS Resolution has offered discretionary funding under its Clinical Negligence Scheme for Trusts (CNST), to provide legal representation for member trusts at inquests. If an application for funding is successful, the trust is supported by one of ten legal 'panel' firms. Panel firms are law firms that have high-quality legal health clinical negligence teams that are contracted by NHS Resolution to provide legal advice for healthcare claims. More information can be found on page 18 of the report.

2. *Learning from suicide-related claims: a thematic review of NHS Resolution data* has been authored by Dr Alice Oates, a Clinical Fellow at NHS Resolution.

3. Emotional and legal support services for those bereaved by suicide can be found on page 112 of the report

About NHS Resolution

NHS Resolution is the operating name of the NHS Litigation Authority.

We provide the following core services to our customers:

- Claims Management delivers expertise in handling both clinical and non-clinical claims to members of our indemnity schemes.

- Practitioner Performance Advice (formerly the National Clinical Assessment Service) provides advice, support and interventions in relation to concerns about the individual performance of doctors, dentists and pharmacists.
- Primary Care Appeals (formerly the Family Health Services Appeal Unit) offers an impartial tribunal service for the fair handling of primary care contracting disputes.
- Safety and Learning service helps to make the NHS a safer place by learning from harm and sharing best practice to reduce future risk.

Visit our website for more information about us: www.resolution.nhs.uk

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