Independent Serious Incident Thematic Review

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Executive Summary

1) Introduction

1.1 Following 19 serious incidents involving the deaths of patients who were in contact with Camden and Islington NHS Foundation Trust services, Wendy Wallace, Chief Executive, commissioned an independent thematic review in line with the Trust’s Serious Incident Procedure.

1.2 The incidents concerned patients who were in contact with the Trust’s psychiatric services during the period November 2013 to May 2014. The purpose of the review was to determine whether the incidents formed a cluster, and to identify any service related themes or issues associated with the incidents.

1.3 The identification of a cluster or clusters is open to interpretation and may range from a simple identification of similar events occurring in proximity to one another spatially or temporally to the more usual understanding in psychiatry, particularly when related to suicidal behaviour, of there being some causative or contributory relationship. The tabulation of the basic information concerning each event enabled the reviewer to discern any obvious connections between the types of event or the individuals involved. As with any detailed examination of a patient’s clinical management, factors highly relevant to good practice but not necessarily directly related to the incident, were identified. The analysis of the investigations provided a useful source of relevant themes for future learning, independent of the question of whether or not the incidents revealed evidence of a cluster.

1.4 The review was undertaken by Dr Clive Robinson, (External Reviewer and Panel Chair), Dr Jonathan O’Sullivan (Deputy Director of Public Health Camden and Islington), Vincent Kirchner (Acting Medical Director), Martin Machray, (Director of Quality & Governance Islington CCG), Dr Alex Warner (Camden CCG Mental Health Clinical Lead (North Locality), Dr Gillian Greenhough (Islington CCG Mental Health Chair and Clinical Lead), Acosia Nyanin, Associate Director, Governance and Quality Assurance C&I). Support to the panel was provided by: Bernadette Hennigan(Interim Risk and Patient Safety Manager) and Margaret ODriscoll (Risk and Patient Safety Manager).

2) Terms of Reference

2.1 The Terms of Reference for the review were as follows:

1) The purpose of this working group is to establish whether there are service related themes or wider issues or links recurring across the cluster of incidents or whether it is chance that this increase in incidents occurred.

2) Given the time in which to complete the review it is recommended that this process focuses on emerging themes and not reinvestigation of individual incidents
or an examination of Trust policies and procedures unless these are directly pertinent to the review.
3) Themes from the previous cluster review should be considered alongside any that are identified from this review.
4) The outcome may include recommendations for the Trust, over and above those identified in the individual serious incident investigation reports, with the expectation that the Trust’s response to any recommendation is fed back to the group.
5) There should be external clinical input to the review.

3) Methodology

3.1 This present review is a hybrid between the two more formal approaches described in Section 3 of the main report. The approach taken has been to examine the outcomes of the 19 serious incident investigations in an open minded way and to systematically draw the main outcomes into broad areas of note, which might develop into themes. Nevertheless this has inevitably been influenced by the reviewer’s individual background, experience and personal preoccupations. It is also the case that there are previously identified themes, which impose a structure to this review either because they have been specifically included in discussion about what needs to be considered or because they are so prominent in the literature about serious incidents that they inevitably require to be considered (communication, risk assessment etc.).

3.2 In addition it may be important to keep in mind that this review is based on material that has already been heavily processed by a variety of investigators. Naturally they have brought their own influence to bear on the interpretation of information and the selection of which issues to highlight in their reports. There have been a number of different approaches used to compile the 19 investigations and this has shaped the context for the thematic review.

4) Context

4.1 Camden and Islington NHS Foundation Trust is the largest provider of mental health and substance misuse services to residents within the London Boroughs of Camden and Islington. The trust also provides substance misuse services in Westminster, and a substance misuse and psychological therapies service in Kingston. The trust has two inpatient facilities, at Highgate Mental Health Centre and St Pancras Hospital, as well as community-based services throughout the two boroughs of Camden and Islington.

4.2 During the period 2006 to 2013, 135 Camden residents and 152 Islington residents were recorded as having died from suicide or from undetermined injury. In addition there were 6 deaths among people with no fixed abode, 104 deaths of
people resident outside the two boroughs, and 20 deaths from suicide or undetermined injury of people with local GPs but resident elsewhere. This data is specific to the total population of the two boroughs and is not isolated to patients of Camden and Islington NHS Foundation Trust.

4.3 Over the period 2001 to 2012 there was a reduction in the number of deaths from the causes set out above. More recent figures have been compatible with the national figure of 10 per 100,000 and London figure of 8 per 100,000.

5) The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness July 2013

5.1 The ‘National Confidential Inquiry’ is an obvious source of comparative data, and contains valuable background information from which to make some judgments about relative incidence and trends. The different method of collection and aggregation of large amounts of data in the ‘National Confidential Inquiry’ does mean that any direct comparisons need to be interpreted with caution.

5.2 During 2001-2011 the ‘National Confidential Inquiry’ identified 13,469 deaths (28% of general population suicides) as patient suicides, that is that the person had been in contact with mental health services in the 12 months prior to death. The figures for suicide by patients showed a rise in 2011, and while the authors recommended that this figure should be interpreted cautiously because at the time the data was incomplete, they were predicting a higher number of patient suicides than in recent years. This is relevant for anyone wishing to interpret the national data in order to make comparisons with local data including in this review.

6) Results of Thematic Review

6.1 The 19 serious incidents relating to patients of Camden and Islington NHS Foundation Trust occurring during the seven month period November 2013 to May 2014 included: one homicide; seven definite or likely suicides; five possible suicides; two attempted suicides; four probable deaths from accident or natural causes.

6.2 A significantly greater number of these patients were from Camden (15, with four coming from Islington). 12 patients were men and seven women. The majority of the male patients had a diagnosis of psychotic illness. Three of the seven female patients had the diagnosis of Emotionally Unstable Personality Disorder.

6.3 The number of suicides identified in this review is more than what might be expected for this time period and this population. It is necessary to understand this in the context of the limitations in making predictions from the ‘expected’ suicide rate, as predicted by the ‘National Confidential Inquiry’. This series of incidents will need to be reviewed in the context of those occurring over the succeeding year to determine if the figures represent an overall genuine increase of significant
proportions.

6.4 Having considered the spread of incidents, their relationship in time and place, and the lack of connections between the individuals involved, we concluded that the presence of a cluster is not suggested.

6.5 It proved possible to correlate demographic and incident data from the National Confidential Inquiry into Suicides and Homicides. The methods used most frequently in both groups also matched those identified within the National Confidential Inquiry.

6.6 The main themes relevant to the data were identified as:

a) ‘Out of hours’ is a critical time for patients and a time when staff must be extra vigilant. This is supported by national data as well as those incidents, from this series, occurring in hospital or staffed accommodation;

b) Although the review did not give any focus to nursing establishments or skill mix, several of the trust’s incident reports considered it important;

c) Several patients had experienced a number of moves between wards and/or supported accommodation in the community during the course of their admission;

d) There were three patient suicides, which took place one month following discharge, however the incident investigations concluded that it was not possible to determine that a longer period in hospital would have averted or altered this outcome in any way;

e) One patient committed suicide whilst under the care of a crisis house which provides an alternative to hospital. This death occurred while the patient was on leave. A number of other incidents took place in or concerned patients in staffed accommodation, such as hostels, though these were not run by the trust. This is consistent with the findings of the National Confidential Inquiry into Suicides and Homicides by people with Mental Illness; the 2013 report states that in recent years there have been more suicides under home treatment or crisis resolution than under in-patient care (all countries);

f) The use of items of clothing such as pyjamas as ligatures on the wards places additional pressure on staff in determining what clothing poses a risk;

g) The use of wardrobe doors, bathroom doors and windows as a means of attachment for a ligature were common to both inpatient and community suicides. The Trust has conducted a further ligature point assessment and dealt with the types of ligature points identified since these deaths, but the
‘National Confidential Inquiry’ report would suggest that this continues to be a national experience and requires constant vigilance and repeated review;

h) In half of the cases there were deficiencies in assessing, recording or addressing risks. This is consistent with early national findings. (A pilot study published in June 2013 undertaken by The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness examined the quality of risk assessment prior to suicide and homicide. After reviewing 81 cases they found that the overall quality of risk assessments was considered unsatisfactory in 36% (n=15) of the patient suicides and 41% (n=16) of the patient homicides. Risk formulations and management plans were the domains most likely to be judged unsatisfactory in both suicides and homicide.);

i) In two of the cases there was uncertainty about nursing staff’s understanding of the observation policy and thoroughness of actual observations;

j) Although in most cases the issue was not directly related to the incident, there were shortcomings found in the comprehensiveness of care planning in a number of cases;

k) In common with most serious incident reports, and as before, in most cases not directly related to the incident itself, communication was identified as an issue in a number of these cases. However, in several cases it was noted that communication between teams and with other agencies such as primary care had been particularly commendable;

l) During discussions within the Working Group it became clear that communication with GPs via discharge summaries has improved considerably since the CQUIN 1 has been in place providing support for the effectiveness of such processes;

m) The Working Group also identified the need for primary and secondary care clinicians and managers to regularly communicate about changes in their protocols that may affect one other. As an example it seems likely that many in primary care are not aware of the implications of the current workings of the Care Programme Approach (CPA) and in particular the consequences of being discharged from the CPA;

n) A Primary-Secondary Care Agreement exists, having been developed in collaboration with the Clinical Commissioning Group (CCG) mental health leads for Camden and Islington, and the Camden and Islington NHS

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1 The CQUIN (Commissioning for Quality and Innovation) payment framework links a proportion of healthcare providers’ income from commissioners to the achievement of local quality improvement goals.
Foundation Trust (C&I). The Working Group considered this would benefit from review and update;

o) The Working Group discussed the thematic review of October 2013 that was set up by the trust to review a peak in incidents that required examination. There was concern that the community change programme may have contributed to these incidents – however the working group from that period did not find that to be the case.

7) Conclusions

7.1 The number of suicides identified in this review is greater than might be expected for this population during this time period. This observation needs to be understood in the context of the difficulties in making predictions from the ‘expected’ suicide rate, as predicted by the ‘National Confidential Inquiry’. Reviewing the figures and current conclusions in the context of those occurring over the succeeding year would be helpful in determining if the figures represent an overall genuine increase of significant proportions.

7.2 The spread of incidents, their relationship in time and place, and the lack of connections between the individuals involved does not suggest the presence of a cluster.

7.3 Should there be a need to convene a similar group in the future it would be helpful to ensure the terms of reference provide an indication of the context of the working group, the timeframe for the groups work, the aims for the meetings of the group, and the ways in which the outcomes from the review will be disseminated. This should include the relevant commissioners, Trust personnel and wider stakeholders.

7.4 Given the relevance of ethnicity, drug use and sexual orientation to psychiatric morbidity it would be helpful to include these factors in any subsequent review of incidents, and to order the data in date sequence.

7.5 Demographic and incident data from the 19 patients in general correlated with that from the National Confidential Inquiry into Suicides and Homicides. The methods used most frequently in both groups also matched those identified within the National Confidential Inquiry.

7.6 Where there was reference to the RiO records the reports indicated that RiO documentation appeared to show that in most instances there were good standards of contact, care and practice in place in the management of those patients.

7.7 Several patients had experienced a number of moves between wards and/or supported accommodation in the community during the course of their admission.
Such moves inevitably disrupt the patient’s delivery of care and relationships with staff. While some moves were for therapeutic reasons and others were unavoidable, some appeared to be for bed management reasons and this is unacceptable practice.

7.8 The first few weeks after discharge need to be considered a period of increased risk, as is highlighted in the literature on suicide prevention.

7.9 It may be helpful for the Trust to review how the services and patient pathway linking to Crisis House and Supported Accommodation operate so as to minimise risk and ensure they are meeting the requisite criteria.

7.10 The Trust has conducted a further ligature point assessment and dealt with the types of ligature points identified in the incident reports, but the ‘National Confidential Inquiry’ report would suggest that this continues to be a national experience and requires constant vigilance and repeated review. The trust is advised to consider an ongoing work programme for this priority.

7.11 In two of the cases there was uncertainty about nursing staff’s understanding of the observations policy and thoroughness of actual observations which suggests that ward managers need to consider how observation is carried out in practice and to keep expected standards under regular audit. (as above)

7.12 Although in most cases the issue was not directly related to the incident, there were shortcomings in the comprehensiveness of care planning in a number of cases.

7.13 Communication was identified as an issue in a number of these cases. However, in several other of the cases it was noted that communication between teams and with other agencies such as primary care had been particularly commendable.

7.14 Communication with GPs via discharge summaries has improved considerably since the CQUIN has been in place providing support for the effectiveness of such processes.

7.15 There is a need for primary and secondary care services to regularly communicate about changes in their protocols that may have an impact on the other services (for example the changes to the way CPA operates).

7.16 Restructuring within an organisation may have significant implications for the care of individual patients (for example changes in care coordinators as teams are restructured requiring a period of time for the new personnel to get to know their new caseload), which would be relevant to other agencies, involved in caring for these individuals.
7.17 Both the ‘National Confidential Inquiry’ and local data supports the observations that there has been a change in the rate of admissions in recent years and that the in-patient population have a more concentrated high morbidity.

8) **Recommendations arising out of the Thematic Review and meeting of the Working Group**

8.1 It is recommended that the figures and conclusions from this paper are reviewed in the context of those occurring over the succeeding year to assist in determining if the figures represent an overall genuine increase of significant proportions.

8.2 It is recommended that any similar group convened in the future should have terms of reference that provide an indication of the context of the working group, the timeframe for the groups work, the aims for the meetings of the group, and the ways in which the outcomes from the review will be disseminated. This should include the relevant commissioners, Trust personnel and wider stakeholders.

8.3 It is recommended that consideration be given to increasing the participation of GPs in relevant serious incident investigations.

8.4 It is recommended that any future thematic should include ethnicity, drug use and sexual orientation, given the relevance of these factors to psychiatric morbidity, and that the incidents should be ordered in date sequence.

8.5 It is recommended that the Trust ensure the action plans arising from these reports are up to date, and that the actions required by those plans are being effectively implemented; in particular those actions relating to:

   i. risk assessment and management
   ii. risks associated with ligature points
   iii. care planning
   iv. observations
   v. communication between teams and with external services
   vi. transfer of care between teams
   vii. discharge planning

8.6 It is recommended that the outcome of this review is fed into the suicide prevention work in both of the boroughs lead by Jonathon O’Sullivan.

8.7 It is recommended that the Trust consider following up all patients discharged within 7 days, and not just those on CPA, as is done currently, via the primary nurse.
8.8 It is recommended that commissioners and providers of primary and secondary care services consider ways to improve regular channels of communication to ensure relevant clinical information is available to those who need it in a timely fashion, and that changes within one service that affects other services are communicated appropriately.

8.9 It is recommended that the Primary and Secondary Care Interface Agreement be reviewed in the light of experience since its inception.

8.10 It is recommended that Islington CCG support Camden & Islington NHS Foundation Trust in obtaining benchmarking data from the CSU.

8.11 It is recommended that Camden & Islington NHS Foundation Trust facilitate a workshop to consider the findings of the review with respect to learning lessons.

Main Report

Thematic Review of the 19 Serious Incidents Involving Patients Receiving Psychiatric Services from Camden and Islington NHS Foundation Trust Occurring During the Seven Months November 2013 to May 2014

1) Introduction

1.1 Following 19 incidents involving patients who were in contact with Camden and Islington NHS Foundation Trust services, Wendy Wallace, Chief Executive, requested that a thematic review of the serious incident investigations should be undertaken in line with the Trust’s Serious Incident Procedure. The review was undertaken by Dr Clive Robinson, (External Reviewer and Panel Chair), Dr Jonathan O’Sullivan (Deputy Director of Public Health Camden and Islington), Vincent Kirchner (Acting Medical Director), Martin Machray, (Director of Quality & Governance Islington CCG), Dr Alex Warner (Camden CCG Mental Health Clinical Lead (North Locality), Dr Gillian Greenhough (Islington CCG Mental Health Chair and Clinical Lead), Acosia Nyanin, Associate Director, Governance and Quality Assurance C&I). Support to the panel was provided by: Bernadette Hennigan (Interim Risk and Patient Safety Manager) and Margaret O'Driscoll (Risk and Patient Safety Manager).
1.2 The incidents involved patients who were in contact with the Trust’s psychiatric services during the period November 2013 to May 2014. The purpose of the review was to determine whether the incidents formed a cluster, and to identify any service related themes associated with the incidents. Initially 16 incident reports were available for analysis but later a total of 19 incidents were identified as having occurred during the period under consideration and when these reports were completed they were added to the review.

1.3 A meeting of the working group convened to consider the review of these incidents at St Pancras Hospital on 28 October 2014. The meeting included representatives of Camden & Islington Public Health, the Mental Health Lead for Camden CCG, the Mental Health Clinical Lead for Islington CCG, the Director of Quality & Governance for the Trust, the Associate Director Governance & Quality Assurance, and the Trust’s Interim Risk & Patient Safety Manager. At that stage only data for the initial group of sixteen incidents was available for consideration.

2) Terms of Reference

2.1 The Terms of Reference for that meeting were as follows:

1) The purpose of this working group is to establish whether there are service related themes or wider issues or links recurring across the cluster of incidents or whether it is chance that this increase in incidents occurred.

2) Given the time in which to complete the review it is recommended that this process focus on emerging themes and not reinvestigation of individual incidents or an examination of Trust policies and procedures unless these are directly pertinent to the review.

3) Themes from the previous cluster review should be considered alongside any that are identified from this review.

4) The outcome may include recommendations for the Trust, over and above those identified in the individual serious incident investigation reports, with the expectation that the Trust’s response to any recommendation is fed back to the group.

5) There should be external clinical input to the review.

2 Context

2.2 In October 2013 the Trust carried out a cluster review that looked at incidents occurring in Q1 13/14. This was in response to the increase in the number of serious incidents and was presumed at that time to be a spike in numbers. The findings of
the review were that although there were some themes that carried across more than one incident, alcohol being the most prevalent factor, there were no factors identified that could be considered to link these incidents in any significant way and there were no additional recommendations for the Trust arising out of the review.

2.3 Representatives of the same organisations had met to review this data and previously during the October 2014 meeting there was some discussion as to whether the group was time limited or part of an on-going series that would review future incidents. It was clarified that this was a separate meeting of a working group convened specifically to consider this group of incidents.

2.4 It was agreed that should there be a need to convene a similar group in the future it would be helpful to ensure the terms of reference provide an indication of the context of the working group, the timeframe for the groups work, the aims for the meetings of the group, and the ways in which the outcomes from the review will be disseminated. This should include the relevant commissioners, Trust personnel and wider stakeholders. In this case the thematic review was commissioned by the Camden and Islington NHS Foundation Trust’s Chief Executive to support local work that the Acute division were doing to consider if there was any immediate learning from these incidents. Findings from this review have been reported to the Trust’s Quality Committee and its board, as well as taken to the Commissioner’s Clinical Quality Review Group, where lessons for the local health and social care systems have been highlighted and the recommendations were approved.

3) Methodology

3.1 Thematic analysis in its simplest form is a categorising strategy for qualitative data. It is a way of identifying, analysing and reporting patterns or themes from information available. If successfully carried out it organises and describes the data distilling it while retaining detail. However it often goes further than this and interprets various aspects of the topic itself (in this case aspects of the incident and its aftermath). Thematic analysis is widely used, but there is no clear agreement about what thematic analysis is and how one should perform it, although many people have written about it.

3.2 One might conduct a thematic review along generally inductive lines or generally deductive lines. In an inductive approach, the themes identified by the process are strongly linked to the information in the material because any assumptions made are driven by the information itself. This means that the process of coding the material occurs without trying to fit the data into a pre-existing model or frame. However the person or persons coding and analysing the material can still heavily influence this process. A deductive approach, on the other hand, is theory-driven. This form of analysis tends to be less descriptive overall because analysis is limited to the predetermined areas to be examined.
3.3 This present review is, in a sense, a hybrid between the two dichotomised approaches described in the previous paragraph. There has been an attempt to examine the outcomes of the 19 serious incident investigations in an open minded way and to systematically draw the main outcomes into broad areas of note, which might develop into themes. Nevertheless this has inevitably been influenced by the reviewer’s individual background, experience and personal preoccupations. In addition there are previously identified themes, which impose a structure to this review either because they have been specifically included in discussion about what needs to be considered or because they are so prominent in the literature about serious incidents that they inevitably require to be considered (communication, risk assessment etc.).

3.4 In addition it may be important to keep in mind that this review is based on material that has already been heavily processed by a variety of investigators. Naturally they have brought their own influence to bear on the interpretation of information and the selection of which issues to highlight in their reports. There have been a number of different approaches used to compile the 19 investigations and this has shaped the context for these thematic review.

3.5 While these factors do not invalidate the attempt to identify service related themes across the incidents under consideration they do suggest the need for caution in making any overarching generalisations that arise from aggregating this possibly disparate data.

3.6 The reviewer read each of the serious incident reports in detail. Some of the basic data regarding the individuals and the incidents, such as the date of the incident, the type of incident, age, gender, when last in hospital etc. were compiled in tabular form for ease of analysis. In response to feedback during the meeting of the working group the original information has been reordered in date sequence. The main points of the analysis and conclusions of each report were also arranged in tabular form under headings designed to encapsulate the areas of concern identified in the original reports. These were then summarised in tables identifying ‘Good Practice’, and ‘Service Delivery Issues and Contributory Factors’.

3.7 The identification of a cluster or clusters is open to interpretation and may range from a simple identification of similar events occurring in proximity to one another spatially or temporally to the more usual understanding in psychiatry, particularly when related to suicidal behaviour, of there being some causative or contributory relationship. The tabulation of the basic information concerning each event enabled the reviewer to discern any obvious connections between the types of event or the individuals involved. As with any detailed examination of a patient’s clinical management, factors highly relevant to good practice but not necessarily directly related to the incident, were identified. The analysis of the investigations provided a useful source of relevant themes for future learning, independent of the question of whether or not the incidents revealed evidence of a cluster.
4) **Context**

4.1 The Camden and Islington NHS Foundation Trust provides services to the two London Boroughs of Camden and Islington. The trust’s services include adult mental health, mental health care of older people, substance misuse services and care for people with learning disabilities. The trust aims to deliver substantial benefits to service users and carers.

4.2 In 2008 the trust became the first Care Trust to successfully achieve Foundation status. Monitor, the independent regulator, authorised the Foundation Trust to operate from 1 March 2008.

4.3 Camden and Islington NHS Foundation Trust is the largest provider of mental health and substance misuse services to residents within the London Boroughs of Camden and Islington. The trust also provides substance misuse services in Westminster, a substance misuse and psychological therapies service in Kingston. The trust has two inpatient facilities, at Highgate Mental Health Centre and St Pancras Hospital, as well as community based services throughout the two boroughs of Camden and Islington.

4.4 Camden had an estimated resident population of approximately 225,140 people in 2013 (Greater London Authority Round 2012-2011 Census based). The age and sex profile of Camden is very similar to that of London but relatively younger than England with significantly greater proportions of younger adults aged between 25 and 40 years. A high proportion and number (73%, 164,300) of Camden’s population is of working age (16-64). Camden is home to a diverse variety of ethnicities and cultures; nearly 35% of Camden’s overall population are estimated to be from a black minority ethnic group (BME) background. The incidence of psychiatric illness is observed to vary across ethnic groups and evidence suggests that BME groups, notably Black Caribbean and Black Africans have a higher incidence of common adult mental health disorders, e.g. Anxiety, depression and phobias. The same can be said of the White Irish community. Camden is ranked the 15th most deprived borough in London out of 33 Local authorities and 74th most deprived borough in England out of 326 local authorities. Camden has the seventh highest rate of Opiate and Crack Cocaine usage in London and significantly higher than England or London which also has implications for the incidence and complications arising out of serious mental health problems. (Data available on Camden Council website).

4.5 Islington has an estimated population of approximately 210,000, is the 14th most deprived local authority in England and the second most densely populated borough in England. The distribution of deprivation in Islington is complex and there is no clear geographical demarcation between deprived and more affluent areas. It is an ethnically diverse borough with a proportionately larger White, Mixed, Black and
smaller Asian populations compared to London as a whole. The population is markedly polarised with respect to socio-economic status; having the eighth highest income of London Boroughs, but also the seventh highest rate of income support claimants in Great Britain and is the fourth most deprived borough in London. (Data available on Islington Council website).

4.6 The organisations responsible for commissioning and providing psychiatric services to the boroughs have observed some differences between the boroughs with significant difficulties with homelessness and drug usage in Camden and a high incidence of psychosis in Islington. The Trust has Crisis Teams working in both boroughs and both Camden and Islington have hostels providing accommodation for people with severe mental illness.

4.7 Given the relevance of ethnicity, drug use and sexual orientation to psychiatric morbidity it would be valuable to include these factors in any subsequent review of incidents.

4.8 During the period 2006 to 2013 135 Camden residents and 152 Islington residents were recorded as having died from suicide or from undetermined injury. In addition there were six deaths among people with no fixed abode, 104 deaths of people resident outside the two boroughs, and 20 deaths from suicide or undetermined injury of people with local GPs but resident elsewhere.

4.9 As can be seen in the graph there was a reduction in the number of deaths from these causes over the period 2001 to 2012. More recent figures have been compatible with the national figure of 10 per 100,000 and London figure of 8 per 100,000,
5) The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness July 2013

5.1 The ‘National Confidential Inquiry’ is an obvious source of comparative data, and contains valuable background information from which to make some judgments about relative incidence and trends. The different method of collection and aggregation of large amounts of data in the ‘National Confidential Inquiry’ does mean that any direct comparisons need to interpreted with caution. For example the ‘National Confidential Inquiry’ report provides rate of suicide per 100,000 of population in the different regions, and an aggregated percentage of 28% carried out by ‘patients’. From this it would be possible to estimate the expected suicide rate for any Trust’s total population and estimating the number to be expected by those receiving (or having received services in the twelve months before death). However the figures are not directly comparable; the rate quoted in the ‘National Confidential Inquiry’ are those deaths where the Coroner has given a verdict of suicide or an undetermined verdict, whereas the Trust figures include all those where suicide is suspected. The local investigation is carried out before the inquest and it may be that some verdicts of ‘Patients’ as well as the general population will not be identified as suicide and as a result effectively deflate or inflate the overall figures. In the same vein the overall estimate of 28% as the proportion of all recorded suicides that
involve ‘Patients’ will contain marked fluctuations between services; a Trust that is successfully providing services to a greater proportion of its population with severe mental illness will have a higher proportion of suicides. The Trust is increasing its reach to the local population, and it has seen a rise in its activity and the numbers of patients it is treating over the last year.

5.2 Nevertheless the report is a valuable reference and some of the main points are quoted below in italics:

5.3 **Suicide in the general population**

There are usually 4,000-4,500 suicides per year, with a male to female ratio of 3:1. Delayed registration means that figures for the most recent years presented in the 2013 Annual Report will increase; Rising figures for 2008 and 2011 are assumed, in part, to reflect financial pressures leading to unemployment and debt.

5.4 **Variation in suicide by NHS region**

There is some variation in suicide rates by region of residence (by NHS England boundaries) The highest rate of suicide was in the North of England at 9.9 per 100,000 population and the lowest in London at 8.0 per 100,000 population.

5.5 **Method of suicide**

The most common methods of suicide were hanging/strangulation (44%), self-poisoning (overdose) (23%), and jumping/multiple injuries (mainly jumping from a height or being struck by a train) (10%). Less frequent methods were drowning (5%), carbon monoxide (CO) poisoning (4%), cutting/stabbing (3%), and firearms (2%).

Over the period 2001-2010 there were changes in method of suicide. Suicide deaths by hanging increased, although they have fallen since a peak in 2008. Deaths by self-poisoning decreased over the same period, and those by jumping/multiple injuries did not change.

5.6 **Patient suicide: numbers and rates**

During 2001-2011, 13,469 deaths (28% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 1,224 patient suicides per year. The report figure for suicide by patients shows a rise in 2011. This figure should be interpreted cautiously as it is a provisional figure based on incomplete data. However, the authors of the report are predicting a higher number of patient suicides than in recent years.

Part of the increase in patient suicide in 2011 may reflect rising numbers of people under mental health care. To address this, those producing the report have calculated rates with figures from the Mental Health Minimum Dataset (MHMDS) as
the denominator. Falling rates are seen from 2004. However, changes in MHMDS methodology means rates in 2011 are not directly comparable to earlier years.

5.7 **In-patient suicide**

There were 1,447 in-patient deaths by suicide during the report period, 11% of patient suicides, an average of 132 per year. From 2001 to 2010, there was a 58% fall in the number of in-patient suicides. The report projects a continuation of this trend in 2011 - a fall to 5% of all patient suicides. Deaths by hanging/strangulation on the ward are usually from low-lying ligature points.

5.8 **Crisis Resolution/Home Treatment**

There were 1,508 suicides in patients under crisis resolution/home treatment teams (CR/HT), 12% of the total sample, an average of 137 deaths per year. Since 2006, there have been 150-200 suicides per year under CR/HT. Since 2006 there have been more patient suicides under CR/HT than in in-patient care, reflecting a change in the nature of acute care. In the last 3 years over twice as many suicides have occurred under CR/HT. 462 (34%) CR/HT patients died within 3 months of hospital discharge. In many of these cases CR/HT will have been used to allow earlier discharge rather than as an alternative to admission. 181 (40%) of these patients died within 2 weeks of discharge. 628 (44%) CR/HT patients lived alone.

5.9 **Patients recently discharged from hospital**

There were 2,480 suicides within 3 months of discharge from in-patient care, 18% of all patients and 21% of suicides by community patients, an average of 225 deaths per year. There was an overall fall in the number of post-discharge suicides between 2001-2010, although the projected figures show a rise in 2011. Post-discharge suicides were most frequent in the first week after leaving hospital when 375 deaths occurred, an average of 34 per year, 15% of all suicides within three months of hospital discharge.

5.10 **Alcohol and drug misuse**

There were 5,880 suicides in patients with a history of alcohol misuse, 45% of the total sample, an average of 535 deaths per year. 4,079 patient suicides had a history of drug misuse, 31% of the total sample, an average of 371 deaths per year. There were 7,055 patients who had a history of either alcohol or drug misuse or both, 54% of patient suicides, an average of 641 deaths per year.

1,115 (8%) patient suicides had a primary diagnosis of alcohol dependence/misuse; 543 (4%) had drug dependence/misuse. The number with alcohol or drug dependence/misuse did not change over the report period.
5.11 Given the limitations of using the national data to compare performance in individual trusts; although more locally derived data must also be interpreted with care, it is likely that demographic data, incident rates, and any significant themes arising out of incident investigations for local boroughs and Trusts would be useful in providing comparative data when monitoring incidents.

5.12 The ‘National Confidential Inquiry’ estimates that the average rate of death from suicide and undetermined injury is between 9.9 and 8 per 100,000 of the population per year nationally, and 8 per 100,000 for London. Given the population of Camden and Islington this would suggest an estimate of 35 deaths per year from these causes using the London figure. The graph in paragraph 4.9 would suggest that deaths in 2009 to 2012 were within that region.

5.13 The equivalent figures for the period relating to this review are not yet available and it is far more difficult to estimate the proportion of deaths in the general population that will be represented in the figures relating to patients of the Trust. In part this will be affected by the degree to which the Trust is successful in providing services to the at risk population it serves.

5.14 During 2001-2011 the ‘National Confidential Inquiry’ identified 13,469 deaths (28% of general population suicides) as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represented an average of 1,224 patient suicides per year. The figures for suicide by patients showed a rise in 2011, and while the authors recommended that this figure should be interpreted cautiously because at the time the data was incomplete, they were predicting a higher number of patient suicides than in recent years. This would have relevance for anyone wishing to interpret the national data in order to make comparisons with local data. Bearing this in mind and using the figure of 28%, the estimate of death from these causes for a London population the size of Camden and Islington would be in the region of 10 per year.

6) Results of Thematic Review

6.1 Considering the 19 serious incidents relating to patients of Camden and Islington NHS Foundation Trust occurring during the seven month period November 2013 to May 2014:

A significantly greater number of these patients were from Camden.
More men than women in this group, twelve were male and seven female.
The majority of the male patients had a diagnosis of psychotic illness.
Three of the seven female patients had the diagnosis of Emotionally Unstable Personality Disorder.

1,970 (15%) patient suicides had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis), an average of 179 deaths per year.
6.2 Of the 19 serious incidents in total they comprise:
   One homicide
   Seven definite or likely suicides
   Five possible suicides
   Two attempted suicides
   Four probable deaths from accident or natural causes

6.3 Two deaths were the result of injuries sustained from being hit by an underground train. These were five months apart and took place at different underground stations.

6.4 Three deaths and two attempted suicides involved hanging. Three of these occurred within nine days of each other, two in the person's home (separate unsupported flats) and one on an inpatient ward. There was nothing in the reports to suggest that the individuals were known to each other or that they were being treated by the same teams at the time of the incidents.

6.5 Of the five incidents (deaths and attempted suicides) that involved hanging, three took place on in-patient wards (two of the incidents were attempts, one death) and involved the use of ligature points. These three incidents took place over a three month period and involved patients under the care of different teams on different wards. In the three years prior to this period there were no inpatient suicides.

6.6 Five of the incidents involved patients living in supported housing, this included three suicides but related to three different hostels and nothing in the reports suggests that the individuals were likely to have known of each other.

6.7 It may be helpful to make a distinction between issues that are pertinent to maintaining good clinical practice and care on the one hand, and those that appear to have a direct causal relationship to the incident itself. So that in examining this group of incidents the question of identifying a cluster and themes associated with serious self-harm would need to be confined to factors directly related to the incident, whereas themes relating to good care may not be directly linked in any way.

6.8 The number of suicides identified in this review is outside what one might expect for this time period and this population. It is necessary to understand this in the context of the limitations in making predictions from the 'expected' suicide rate, as predicted by the 'National Confidential Inquiry'. This series of incidents will need to be reviewed in the context of those occurring over the succeeding year to determine if the figures represent an overall genuine increase of significant proportions.

6.9 Having considered the spread of incidents, their relationship in time and place, and the lack of connections between the individuals involved, there is no suggestion as to the presence of a cluster.
6.10 Demographic and incident data from the 19 patients in general correlated with that from the National Confidential Inquiry into Suicides and Homicides. The methods used most frequently in both groups also matched those identified within the National Confidential Inquiry.

6.11 Where there was reference to the RiO records the reports indicated that RiO documentation appeared to show that in most instances there were good standards of contact, care and practice in place in the management of those patients. The present review did not have direct access to RiO documentation and is dependent upon the judgments of the investigators who sometimes but did not invariably comment on the quality of practice.

6.12 The main themes relevant to the data are listed in the following section (with the Trust’s current actions in italic parenthesis where appropriate):

I. That ‘out of hours’ is a critical time for patients and a time when staff must be extra vigilant. This is supported by national data as well as those incidents, from this series, occurring in hospital or staffed accommodation.

II. In an earlier review of incidents conducted by Bernadette Hennigan (Interim Risk & Patient Safety Manager) the time when inpatient incidents took place is also noteworthy, with all but one incident taking place out of hours and with 5pm to midnight being the most prevalent time. The timing of these incidents is probably not surprising given that staff including occupational therapists, psychologists, doctors, care coordinators, social workers etc have left for the day and patient visiting time has ended. In the evening patients have more time to themselves to contemplate their situation, their future, thoughts and feelings. In addition there is less therapeutic interventions on the wards after 5pm and nursing staffing numbers are lower at night (from 8pm) limiting therapeutic engagement further. Of particular interest is that the majority of the incidents which took place out of hours only one incident took place before 6pm.

III. Although the review did not give any focus to nursing establishments or skill mix, several reports considered it important that this should be taken into account in the Trust’s work on Safer Staffing alongside any restructuring and remodelling of inpatient services.

IV. Several patients had experienced a number of moves between wards and/or supported accommodation in the community during the course of their admission. ‘The National Confidential Inquiry’ identifies the changes in service provision and bed pressures as relevant factors in the changing pattern of suicide nationally. Services need to be vigilant to minimise the impact of these
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factors on the continuity of care and to avoid the risks of care being fragmented.

V. (The Trust in conjunction with its partners at the Quality Summit in August 2014, following the full Care Quality Commission inspection of its services, produced the following plans to address these issues. Bed management rules that have been introduced in recent months to ensure that:

1) No patient shall be moved from one site to the other as a “sleep over” patient.

2) No patient who has retired to bed for the night, will be woken up to be moved for bed management reasons.

We are committed to ensuring that any bed moves are kept to the absolute minimum.

To reinforce this, the Chief Executive, has confirmed through a trust-wide communication that whenever a patient has been assessed as needing a bed and there is no bed available within the Trust, then a bed will always be found via the agreed escalation process. During the day this will be with the authorisation of the Chief Operating Officer and out of hours by the Director on-call. Under no circumstances, will a patient be left to sleep anywhere other than in a bed.

VI. In order to monitor the position and ensure that action can be taken to improve practice in this area, all moves for bed management reasons must be reported as an incident via Datix, the trust's incident reporting system).

VII. (The Trust has indicated that the following processes have been put in place to further improve the Trust’s bed management. These have been shared with the CQC:

1) The Trust will continue to take a system wide approach to improving the effectiveness of all services, as one way to reduce the pressure on the acute care pathway.

2) The Trust will undertake a deep dive review of the acute care pathway taking a whole systems approach to establish the patient profile and identify where the pressures in the system are.

3) The Medical Director will undertake a case note review of in-patients in order to probe and challenge practice and help ensure that the acute beds are used effectively.

4) The Trust will enhance the acute care pathways by the continued review by the bed management team, providing Band 6 nurses out of hours at the St Pancras site, increasing consultant time in the crisis pathway, urgently recruiting to the vacant consultant posts, implementing a revised model of
consultant input on the Psychiatric Intensive Care Unit (PICU), setting up a working group to examine delivery of seven day working for consultants.

5) The Trust will formalise and strengthen the informal agreements concerning patient transfers into a clear protocol for the management of transfers between wards and bed management to ensure that patients are transferred safely and that there is continuity of care and treatment.

6) There is currently an audit of ward moves examining the number and circumstances leading up to the decision to move an individual, in order to probe and challenge current practice.)

VIII. There were three patient suicides, which took place one month following discharge however the incident investigations concluded that it was not possible to determine that a longer period in hospital would have averted or altered this outcome in any way. Nevertheless, since this is also a national phenomenon, the first few weeks after discharge need to be considered a period of increased risk.

IX. (The Trust is required to follow up all service users on CPA within 7 days of discharge from an inpatient unit. This is a key indicator for the Trust in terms of performance but it is also considered to be a very important part of the care provide to patients and is primarily aimed at reducing suicides. Evidence indicates that for service users recently discharged from hospital there is a peak in suicide in the first 1-2 weeks following discharge. It has also been found that 40% of suicides occur before the first follow up appointment after discharge. Since 2002, following on from The National Suicide Prevention Strategy for England it has been a national target to follow up service users within seven days of discharge. Given the increased risk during this period the working group recommended that the Trust consider following up all patients discharged within seven days via the primary nurse.).

IX. One patient committed suicide whilst under the care of a crisis house which provide an alternative to hospital. The patient was on leave from the crisis house at the time of their death. A number of other incidents took place in or concerning patients in staffed accommodation, in a range of facilities run by a number of organisations throughout the two boroughs. This is consistent with the findings of the National Confidential Inquiry into Suicides and Homicides by people with Mental Illness; the 2013 report states that 'In recent years there have been more suicides under home treatment or crisis resolution than under in-patient care (all countries)'. Nowhere else in London is the model of using crisis houses implemented to this extent and so there is no data to make useful comparisons. It was beyond the scope of this review to consider these cases in detail but it may be helpful for the Trust to review how the services linking to these facilities operates so as to minimise risk and ensure they are meeting the requisite criteria.
X. The use of items of clothing such as pyjamas as ligatures on the wards places additional pressure on staff in determining what clothing poses a risk.

XI. (The Trust has a comprehensive ‘Search Policy’ supporting the objective of the removal of alcohol, drugs and other illicit substances, from inpatient settings, which could have a negative impact on a patient’s recovery as well as items that could be used as weapons. The policy provides advice on when, how searches should be performed, and recorded and links these to appropriate risk assessment.)

XII. The use of wardrobe doors, bathroom doors and windows as a means of attachment for a ligature were common to both inpatient and community suicides. The Trust has conducted a further ligature point assessment and dealt with the types of ligature points identified, but the ‘National Confidential Inquiry’ report would suggest that this continues to be a national experience and requires constant vigilance and repeated review.

XIII. In 50% of the cases there were deficiencies in assessing, recording or addressing risks. This is in keeping with the majority of serious incident reports from all Trusts.

XIV. In two of the cases there was uncertainty about nursing staff’s understanding of the observation policy and thoroughness of actual observations. (The Trust has put in place a process by which a single Care Plan for each patient is available to all members of the clinical team, which includes a review of the risk assessment and risk management plan, observation records and current observation level. This is monitored within the individual and team supervision process).

XV. Although in most cases not directly related to the incident, there were shortcomings in the comprehensiveness of care planning in a number of cases.

XVI. In common with most serious incident reports, and as before, in most cases not directly related to the incident itself, communication was identified as an issue in a number of these cases. However in several other of the cases it was noted that communication between teams and with other agencies such as primary care had been particularly commendable.

XVII. During discussions within the Working Group it became clear that communication with GPs via discharge summaries has improved considerably since the CQUIN has been in place providing support for the effectiveness of such processes.
XVIII. These discussions of the Working Group also identified the need for primary and secondary care to regularly communicate about changes in their protocols that may affect the other. As an example it seems likely that many in primary care are not aware of the implications of the current workings of CPA and in particular the consequences of being discharged from the CPA.

XIX. A Primary-Secondary Care Agreement exists, having been developed in collaboration with the Clinical Commissioning Group (CCG) mental health leads for Camden and Islington, and the Camden and Islington NHS Foundation Trust (C&I). This agreement outlines the mutual roles and responsibilities of primary and secondary care services in the management of people with mental health problems ranging from mild to severe and complex. The aim was to set standards and agree working arrangements that will promote effective communication and enhance partnership working. The objective is for patients to experience a seamless care pathway through the local health system with improved health outcomes by providing properly integrated care.

XX. (The Agreement is a clinically orientated document containing agreements in C&I contracts. Where there is a discrepancy between this document and a signed contract the latter takes precedence. The Working Group agreed that the arrangements for reviewing the Agreement will be brought forward so as to update and incorporate any Mental Health tariff guidance which may impact upon it.).

XXI. Similarly restructuring within an organisation may have significant implications for the care of individual patients (for example changes in care coordinators as teams are restructured requiring a period of time for the new personnel to get to know their new caseload). This in turn may have significant implications for primary care. We did not find that this was a common theme in this cohort of patients. It featured significantly in one case however.

XXII. The Working Group discussed the thematic review of October 2013 which was set up to review a peak in incidents that required examination. There was concern that the community change programme may have contributed – however the working group from that period did not find that to be the case.

7) **Conclusions**

7.1 The number of suicides identified in this review is outside what one might expect for the population in this time period. This observation needs to be understood in the context of the difficulties in making predictions from the ‘expected’ suicide rate, as predicted by the ‘National Confidential Inquiry’. Reviewing the figures and current conclusions in the context of those occurring over the succeeding year would be helpful in determining if the figures represent an overall genuine increase
of significant proportions.

7.2 The spread of incidents, their relationship in time and place, and the lack of connections between the individuals involved does not suggest the presence of a cluster.

7.3 Should there be a need to convene a similar group in the future it would be helpful to ensure the terms of reference provide an indication of the context of the working group, the timeframe for the groups work, the aims for the meetings of the group, and the ways in which the outcomes from the review will be disseminated. This should include the relevant commissioners, Trust personnel and wider stakeholders.

7.4 Given the relevance of ethnicity, drug use and sexual orientation to psychiatric morbidity it would be helpful to include these factors in any subsequent review of incidents, and to order the data in date sequence.

7.5 Demographic and incident data from the 19 patients in general correlated with that from the ‘National Confidential Inquiry into Suicides and Homicides’. The methods used most frequently in both groups also matched those identified within the ‘National Confidential Inquiry’.

7.6 Where there was reference to the RiO records the reports indicated that RiO documentation appeared to show that in most instances there were good standards of contact, care and practice in place in the management of those patients.

7.7 Several patients had experienced a number of moves between wards and/or supported accommodation in the community during the course of their admission. Such moves inevitably disrupt the patient’s delivery of care and relationships with staff. While some moves were for therapeutic reasons and others were unavoidable, some appeared to be for bed management reasons.

7.8 The first few weeks after discharge need to be considered a period of increased risk. This is particularly the case for the first seven days following discharge.

7.9 It may be helpful for the Trust to review how the services linking to Crisis House and Supported Accommodation operate so as to minimise risk and ensure they are meeting the requisite criteria.

7.10 The Trust has conducted a further ligature point assessment and dealt with the types of ligature points identified in the incident reports, but the ‘National Confidential Inquiry’ report would suggest that this continues to be a national experience and requires constant vigilance and repeated review.
7.11 In two of the cases there was uncertainty about nursing staff’s understanding of the observation policy and thoroughness of actual observations.

7.12 Although in most cases not directly related to the incident, there were shortcomings in the comprehensiveness of care planning in a number of cases.

7.13 Communication was identified as an issue in a number of these cases. However in several other of the cases it was noted that communication between teams and with other agencies such as primary care had been particularly commendable.

7.14 Communication with GPs via discharge summaries has improved considerably since the CQUIN has been in place providing support for the effectiveness of such processes.

7.15 There is a need for primary and secondary care services to regularly communicate about changes in their protocols that may have an impact on the other services (for example the changes to the way CPA operates).

7.16 Restructuring within an organisation may have significant implications for the care of individual patients (for example changes in care coordinators as teams are restructured requiring a period of time for the new personnel to get to know their new caseload), which would be relevant to other agencies, involved in caring for these individuals.

7.17 Both the ‘National Confidential Inquiry’ and local data supports the observations that there has been a change in the rate of admissions in recent years and that the in-patient population have a more concentrated high morbidity.

8) Recommendations arising out of the Thematic Review and meeting of the Working Group

8.1 It is recommended that the figures and conclusions from this paper are reviewed in the context of those occurring over the succeeding year to assist in determining if the figures represent an overall genuine increase of significant proportions.

8.2 It is recommended that any similar group convened in the future should have terms of reference that provide an indication of the context of the working group, the timeframe for the groups work, the aims for the meetings of the group, and the ways in which the outcomes from the review will be disseminated. This should include the relevant commissioners, Trust personnel and wider stakeholders.

8.3 It is recommended that consideration be given to increasing the participation of GPs in relevant serious incident investigations.
8.4 It is recommended that any future thematic review should include ethnicity, drug use and sexual orientation, given the relevance of these factors to psychiatric morbidity, and that the incidents should be ordered in date sequence.

8.5 It is recommended that the Trust ensure the action plans arising from these reports are up to date, and that the actions required by those plans are being effectively implemented; in particular those actions relating to:

- risk assessment and management
- risks associated with ligature points
- care planning
- observations
- communication between teams and with external services
- transfer of care between teams
- discharge planning

8.6 It is recommended that the outcome of this review is considered by the suicide prevention strategy being prepared for both boroughs led by Jonathon O'Sullivan.

8.7 It is recommended that the Trust consider following up all patients discharged within 7 days, and not just those on CPA, as is done currently, via the primary nurse.

8.8 It is recommended that commissioners and providers of primary and secondary care services consider ways to improve regular channels of communication to ensure relevant clinical information is available to those who need it in a timely fashion, and that changes within one service that affects other services are communicated appropriately.

8.9 It is recommended that the Primary and Secondary Care Interface Agreement be reviewed in the light of experience since its inception.

8.10 It is recommended that Islington CCG support Camden & Islington NHS Foundation Trust in obtaining benchmarking data from the Clinical Support Unit (CSU)

8.11 It is recommended that Camden & Islington NHS Foundation Trust facilitate a workshop to consider the findings of the review with respect to learning.

8.12 An action plan should be drawn up by the trust to address the recommendations of the independent review.