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Norfolk and Suffolk NHS Foundation Trust: Early Intervention in Psychosis Team Pathway Review

June 2023

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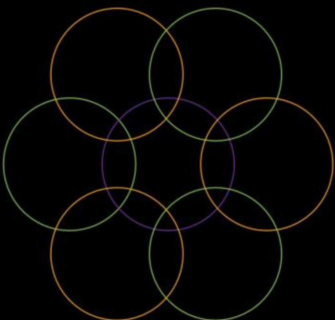

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Letter of transmittal

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27 June 2023

Norfolk and Suffolk NHS Foundation Trust: Early Intervention in Psychosis Team Pathway Review

This Final Report has been written in line with the terms of reference for the pathway review as set out in our proposal dated 21 March 2022. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

This report was commissioned by NHS England and cannot be used or published without their permission. No other party may place any reliability whatsoever on this report as this has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final, approved version of this report, the 'Final Report' should be regarded as definitive.

Yours faithfully,

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1. Introduction

1. Introduction

1.1 Context

On 5 August 2017, a 23-year-old man killed an 84-year-old gentleman who had been walking his dog in a remote wooded area in Norfolk. Following his subsequent arrest and trial, the young man was convicted of murder, and received a sentence of life imprisonment with a minimum term of 28 years in prison.

At the time of the homicide the young man was not under the care of mental health services, but he had had three previous episodes of care provided by Norfolk and Suffolk NHS Foundation Trust (NSFT or 'the Trust'), between 2014 and 2017 as follows:

- April 2014 to May 2014 – involving the Youth Service;
- April 2015 to May 2016 – involving the Crisis Resolution and Home Treatment Team (CRHTT) and the Early Intervention in Psychosis Service (EIS); and
- December 2016 to March 2017 - involving a different EIS team in the Trust.

Given this previous contact with mental health services, the Trust commissioned an independent investigation. This investigation was completed on 9 November 2018. The report made twelve recommendations to improve the care and treatment of service users, especially those in contact with the EIS, and three recommendations to improve practice following a serious incident.

In early 2022, Niche Health and Social Care Consulting (Niche) were appointed by NHS England to conduct a review of the NSFT EIT pathway to determine:

"If a service user accessed services today with a similar history/problem - what would have changed/be different?"

The terms of reference provided by NHS England were:

- Identify the issues arising from this case and carry out a review of the current pathway with reference to these issues.
- Review the current discharge processes from Early Intervention in Psychosis Team services and stability of staffing.
- Review the development of the present-day service provision governance and quality systems, arrangements for identifying and escalating risks, and opportunities for improving the quality of services.
- Review and assess compliance with local policies, national guidance and statutory obligations in the present day.
- The review process should also identify areas of good practice, opportunities for learning and areas where improvements to services may be required.
- Involve the families of both the victim and the service user as fully as is considered appropriate, and if they have any questions attempt to answer them.
- Provide a written report to NHS England that includes measurable SMART and sustainable recommendations that have been co-produced with the affected organisations.
- Produce a learning document, suitable for sharing with other providers, on the learning from the investigation.

To meet the terms of reference, an audit of 71 case notes (100% of discharges that met the set criteria) was conducted between August and November 2022 to determine if changes arising from the 2018 investigation report were evident in practice.

1. Introduction (cont.)

1.2 Recommendations from the 2018 report

We studied the 2018 investigation report to understand the key issues identified. This report highlighted three care and service delivery problems, none of which was deemed to contribute to the final outcome. These were as follows:

- **The lack of continuity in care from the CRHTT,** caused by the multiple practitioners involved in delivering care and treatment to the service user.
- **The quality of risk assessments,** and particularly the non-compliance with the Trust's Clinical Risk Assessment and Management Policy.
- **Poor discharge arrangements** applied to the service user's discharge from his third and final episode of care with NSFT.

The 2018 investigation report produced 12 recommendations to support improvements in practice. Nine of these related to pathway processes and practice which are relevant to the scope of this audit. These are:

1. CRHTT to review their approach to patient allocation with the aim of reducing the number of staff involved with an individual service user and providing greater continuity of care for service users.
2. Develop guidance for practitioners in recording a systematic approach to formulation and providing a working diagnosis.
3. Support for the current clinical strategy to develop a Trust-wide systematic team approach to formulation based on the 5Ps approach, whilst retaining an emphasis on working diagnosis.
4. The EIT Clinical Team Leader (CTL) to provide assurances and evidence that systems are in place to ensure a named case manager/care coordinator is provided for each service user under the care of the EIT.
5. The EIT to review the last four bi-annual audits of risk assessments (covering last two years practice) and identify the quality of practice and level of compliance with the current Clinical Risk Assessment and Management Policy.
6. The EIT to undertake an audit of discharges over a recent three-month period since this incident to provide assurance that custom and practice within the team is compliant with the Discharge from Trust Services Policy.
7. Consultant Psychiatrists and other practitioners recording assessments or reviews in summary letters to GPs must also record/cut and paste these interventions into the chronological clinical history.
8. The EIT to adopt the practice of ensuring any discussions relating to an individual service user that take place in the EIT multi-disciplinary team (MDT) meeting or between members of the treating team or others are recorded in the clinical history of the relevant service user.
9. Develop a clear protocol for Mental Health Act (MHA) assessments to be routinely loaded onto the electronic patient record (Lorenzo) confirming how and by whom this is done.

Recommendations 10 to 12 relate to serious incident management and post-incident support. They are not included in the audit of individual case files.

1. Introduction (cont.)

1.3 Context of Early Intervention in Psychosis (EIP) Teams in England

It is over 20 years since EIP services were described in the Mental Health Policy Implementation Guide (PIG)[1] for England and Wales. EIP is a model of service delivery to support young people with a first episode of psychosis, its goals being provision of best available treatments, supporting recovery and preventing relapse. EIP services aim to minimise the duration of untreated psychosis and to detect individuals who may be at high risk of developing enduring psychosis. It uses ways of working that are distinct from other psychiatric services; these include provision across the adult-child divide (typically serving 14–35-year-olds but expanded in England to 65 years of age), working with diagnostic uncertainty, a staged model for treating psychosis, understanding and maintaining developmental trajectories, together with a focus on family, education, vocation and psychosocial interventions.

There is data for both the clinical and cost-effectiveness of EIP[2]. Within EIP, patients have lower rates of detention under the MHA, achieve higher employment levels and lower rates of suicide compared to generic services[3]. Cost effectiveness is achieved by the reduction of relapse rates and inpatient occupancy, and an increase in paid employment[4]. A Cochrane Review demonstrated evidence for specialist EIP services improving outcomes for those with first episode of psychosis, but with a question remaining as to whether such gains are maintained[2]. Despite this economic and clinical evidence, and the growth of EIP in the first decade after the PIG, EIP provision across the UK subsequently began to decline, with services being disbanded, becoming age independent, or their functions merged with other teams. Reductions in services have, in some areas, diluted the EIP model so as to be offering essentially generic community services which are unlikely to offer the potential clinical benefits[4].

The introduction of the Access and Waiting Time standard (AWT)[5] in 2016 for EIP, and its subsequent monitoring in the annual NHS England National Clinical Audit (NCAP), has helped embed EIP and support the service standards, despite ongoing challenges in the NHS workforce, and the acuity of the clinical cases presenting to services.

The AWT standard includes two prongs: one for assessment and start of treatment, and one for the nature of that treatment. For the former, this includes a maximum of a two-week wait from referral to the start of the treatment; this incorporates an initial assessment, being allocated to and engaged by an EIP care coordinator (with a specified caseload), and that the EIP service is able to provide a NICE-concordant package of care. For the latter, a NICE-concordant package of care includes cognitive behavioural therapy for psychosis, family intervention, physical health assessments and monitoring, wellbeing support, carer-focussed education and support, education and employment support, and initiation of Clozapine when indicated.

These EIP-specific treatments would also include, and be supplemented by, wider elements important to care including: appropriate risk assessment and management; prescribing of antipsychotic medication and assessing and treating psychiatric comorbidity when required; and smooth integration with other elements of clinical services (for example, crisis resolution and home treatment, inpatient services).

1. The Mental Health Policy Implementation Guide. Department of Health, 2001
2. Marshall M, Rathbone J. Early intervention for psychosis. Schizophrenia Bulletin 2011; 37: 1111–4.
3. ReThink. Lost Generation. 2014.
4. Fowler D, Hodgekins J, Howells L, Millward M, Ivins A, Taylor G, et al. Can targeted early intervention improve functional recovery in psychosis? A historical control evaluation of the effectiveness of different models of early intervention service provision in Norfolk 1998-2007. Early Intervention in Psychiatry 2009; 3: 282–8.
5. NHS England, the National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence (NICE) (2016). Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance. London: NHS England

2. Method

2. Method

2.1 Case note audit - introduction

Following detailed review of the case underlying this audit, an initiation meeting was held to discuss the method and an audit template was agreed between Niche, the Trust and their commissioners in Norfolk. The audit template set out the questions against which the case notes would be audited. The full template is included in Appendix 2 to this report. To develop the audit questions, we considered:

- compliance with local polices, national best practice and guidance;
- arrangements for identifying and escalating risks;
- current discharge processes;
- governance and quality systems (where identifiable within case notes); and
- opportunities for quality improvement.

The audit was undertaken by a Senior Associate within Niche, and sample testing was undertaken by a Director within Niche to ensure the consistency of individual case audits.

The 12 audit questions were:

Care, treatment and support

1. It is clear who the current care coordinator or the lead professional is at the point of discharge from EIT.
2. *If applicable:* the health record includes details of any changes to the care coordinator or lead professional.
3. Records relating to the last two encounters and/or interventions prior to discharge show who was involved and the outcome.
4. *Where a Mental Health Act assessment has taken place*: the assessment by the Approved Mental Health Professional (AMHP) is available in the health record.
5. *Where a Mental Health Act assessment has taken place*: details of the MHA assessment completed by doctors are available in the electronic health record.

Risk assessment and management

6. There is a combined risk assessment and management plan for the episode of care prior to discharge from the EIT. This has been reviewed within one year prior to discharge.
7. There is a record of the risk formulation in the person's electronic health record.
8. There is a crisis plan (within one year prior to discharge).

Discharge processes

9. There is a record of the involvement of the person and their family/carer (as appropriate) in discharge planning.
10. There is evidence of discussion with members of the MDT and/or any others involved in the person's care prior to discharge.
11. Information relating to discharge has been shared with the service user.

Sharing information with GPs

12. The GP has been provided with discharge information within 72 hours of discharge.

2. Method (continued)

2.2 Criteria for inclusion

The audit sampled 81 case notes from the following services:

Services audited	
Early Intervention in Psychosis Services (Norfolk and Waveney) • Central Norfolk • Great Yarmouth and Waveney • West Norfolk	Early Intervention in Psychosis Services in Suffolk • Wickham Market • Bury St. Edmunds

The time period for the data collection was 1 July 2021 to 30 June 2022, and only cases which were open for at least part of this period were included.

The other criteria for inclusion were:

- Service users were aged between 18-65 at the time of their discharge from the EIT.
- Service users had a diagnosed psychotic disorder.
- Service users were referred to and assessed by the EIT (including any period of support) and were then discharged from EIT services in NSFT.

This sample included a sub-set of people who:

- Had been subject to care coordinator or lead professional changes during the episode of review, including transfers of care to other teams in NSFT or to other services; and/or
- Had been assessed under the MHA during their contact with the EIT or within the year prior to their contact with the EIT.

A maximum of 20 minutes was allocated to audit each set of case notes because information which is very difficult to retrieve is of limited clinical use.

Ten cases in the sample of 81 records provided by NSFT did not fully meet the criteria set out above. This led to a total review sample of 71 cases ultimately being audited. The reasons for exclusion were:

Number	Episodes not meeting criteria
5	Transferred between EIP teams in NSFT – no discharge files to review.
1	Patient had planned to move areas, but this did not happen and they remained on the EIT caseload.
1	Urgent referral for discharge, referral re-opened as routine and this (latter) episode has been included in review.
1	Patient referred while an inpatient, assessed but did not meet criteria – no discharge files to review.
2	Unexpected death, no discharge files to review.

2. Method (continued)

2.3 Services

The 71 cases included in the audit were split across the following services:

Central Norfolk	Great Yarmouth and Waveney	West Norfolk	Suffolk	Total
37	14	3	17	71

2.4 Demographics

The demographics of the cases reviewed are set out in the tables below.

Gender	Male	Female
Totals	51	20

Age	18 – 25	26 - 35	Total	Average age
Totals	27	43	71	27

Ethnicity	Any other ethnic group	Asian or Asian British	Black or Black British - Caribbean	Not known/ stated	Other ethnic group - Chinese	White - Any other white background	White British
Totals	1	4	3	12	1	6	44

2.5 Length of time in the EIT

Of the 71 cases reviewed, the length of time in receipt of services from EIT was:

Under 1 month	1 month to 1 year	1 to 2 years	2 to 3 years	Over 3 years
5	19	12	23	12

The average length of time spent under the care of the EIT was 1 year and 9 months. The longest time in receipt of care from the EIT was 8 years.

2. Method (continued)

2.6 Action planning

Staff in the service were sent a copy of this report in draft version in January 2023, at which point they checked its content for factual accuracy. Relevant changes have been reflected in this final draft version. We then held an action planning meeting with service leads in February 2023 during which we shared an action plan template with the service and discussed the key points of our report.

Service managers and clinical leads devised a response to our audit findings, which was approved in their service governance meetings. The action plan response is set out at Appendix 1. The action plan is independent of this audit and Niche has not quality assured its content nor made any judgements as to the appropriateness of actions identified.

3. Findings

3. Findings

The audit findings are summarised in the tables that follow. The definitions of ‘acceptable’ and ‘good’ and the original recommendation they relate to are set out in Appendix 2.

3.1 Care, treatment and support

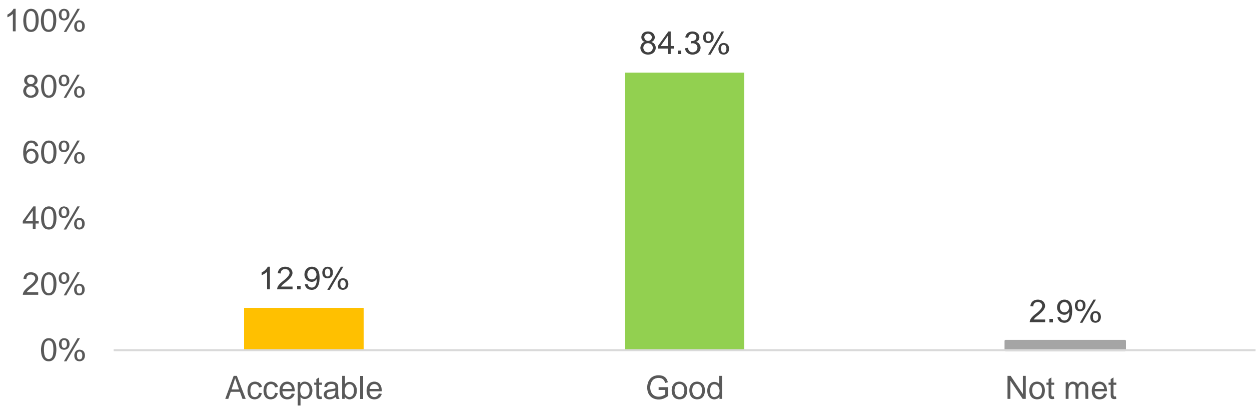
Table 1: Audit results for NSFT records by audit question.

Audit question	Acceptable	Good	Not met	Not applicable	Total applicable
1. It is clear who the current care coordinator or the lead professional is at the point of discharge from the EIT	9	59	2	1	71
2. If applicable: The health record includes details of any changes to the care coordinator or lead professional	6	18	8	39	32
3. Records relating to the last two encounters and/or interventions prior to discharge show who was involved and the outcome	11	124	2	5	137
4. Where a Mental Health Act Assessment has taken place: The assessment by the Approved Mental Health Professional is available in the health record	1	36	1	33	38
5. Where a Mental Health Act Assessment has taken place: Details of the MHA assessment completed by doctors are available in the electronic health record	3	33	2	33	38

3. Findings (continued)

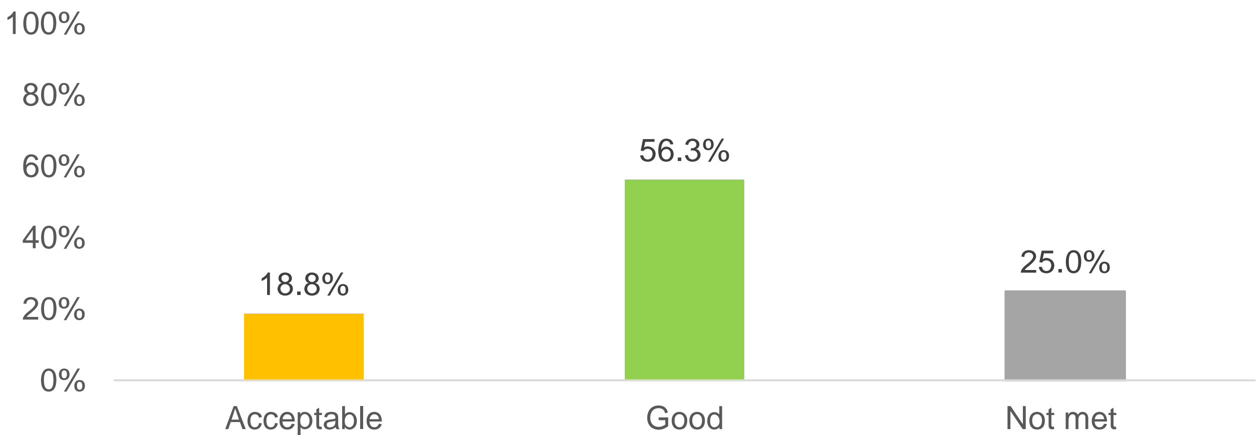
3.1 Care, treatment and support (cont.)

Chart 1: % of records classified as ‘Good’, ‘Acceptable’ and ‘Not met’ for question 1



The details of the care coordinator or lead professional at the point of discharge could easily be found in 85% of cases. In 12.9% of cases, the information was not immediately available, but reviews of letters and/or clinical notes identified the last professional to work with the patient in the EIT. There were two cases of non-compliance with the audit question; this appeared to be due to limited or no engagement by the patient and a different member of the EIT attempting contact.

Chart 2: % of records classified as ‘Good’, ‘Acceptable’ and ‘Not met’ for question 2

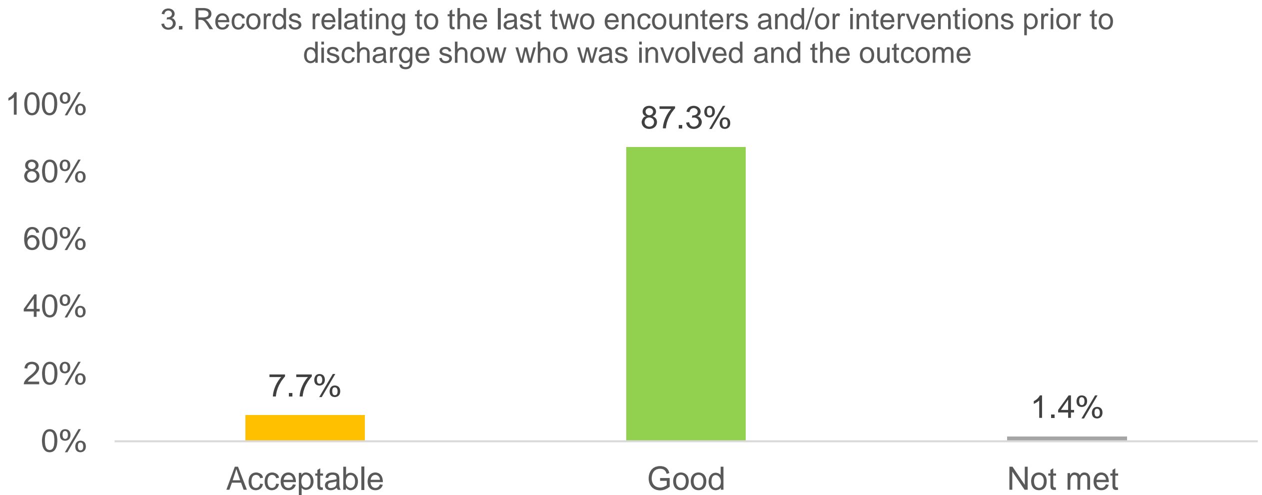


In 32 of the 71 cases, there had been a change of care coordinator or lead professional. For 56.3% of these changes there was good evidence of handover with updated safety plans or combined risk assessments to support the change. In 18.8% of changes, there was no evidence of a clear update or handover completed, although the change in care coordinator had been noted in the electronic files. For 25%, the change could be seen by reviewing the lead professionals for contact with the patient, but no clear handover or recognition of change in clinical notes or charts could be found. This included one patient who had been sent to prison without any handover letter or record of discussion with the prison In-Reach Team.

3. Findings (continued)

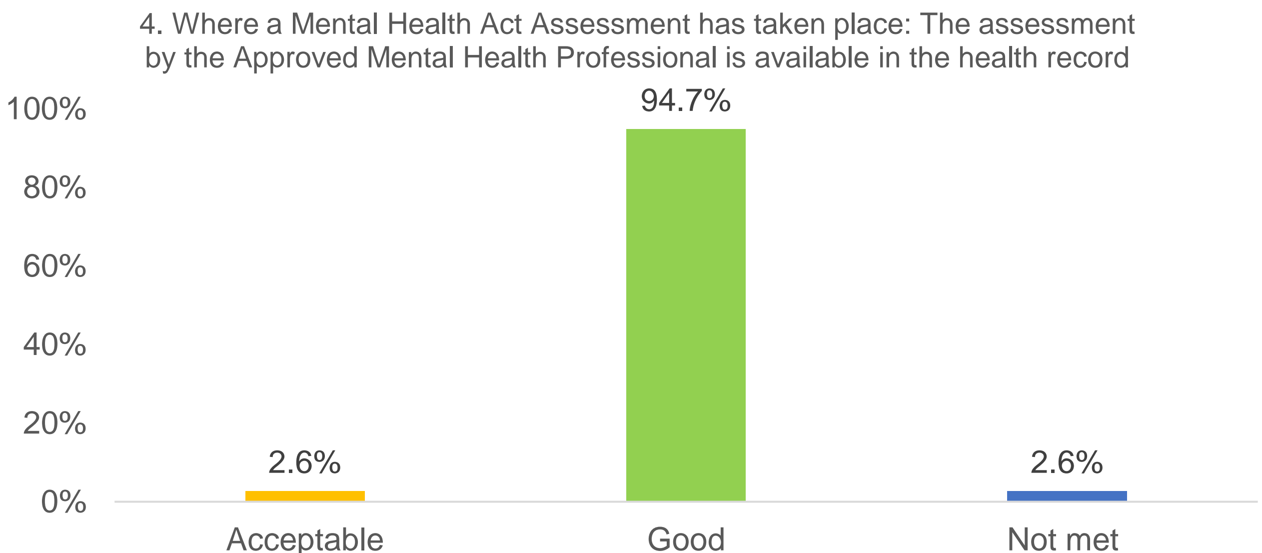
3.1 Care, treatment and support (cont.)

Chart 3: % of records classified as ‘Good’, ‘Acceptable’ and ‘No’ for question 3



There was evidence of the type of contact, name and role of staff involved and details of action or outcome of the intervention and next steps in almost 90% of the cases we reviewed. This included a broad range of activities including provision of medication, final meetings with the patient and/or their families. In some cases, where the patient had disengaged from the service, details of the attempts made to contact the person or coordinate with other services were recorded. In the one case (two encounters reviewed relating to the same patient) where this was not met, this appeared to be due to the person becoming an inpatient and the EIT handed over responsibility to the inpatient team without full discharge processes being applied.

Chart 4: % of records classified as ‘Good’, ‘Acceptable’ and ‘No’ for question 4

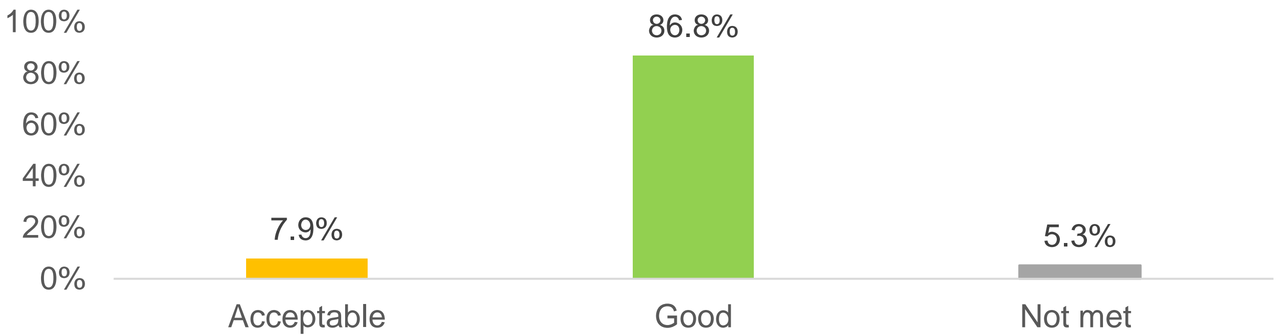


In almost all cases we reviewed where an MHA assessment had taken place, there was a scanned copy of the AMHP’s assessment uploaded onto the patient record and this was easily accessible.

3. Findings (cont.)

3.1 Care, treatment and support (cont.)

Chart 5: % of records classified as 'Good', 'Acceptable' and 'No' for question 5



There was good evidence in over 85% of files reviewed that the NSFT doctors had entered information relating to the person's mental state, diagnosis, rationale for MHA assessment and outcomes into the patient's clinical notes. In almost all cases, this was supported by scanned documents of the assessment that were easily accessible in the electronic record. In two cases, the medical recommendations or supporting information could not be found. In one of these cases, this related to a section that had been completed as part of a court process and the supporting medical recommendations had not been uploaded to the file.

3.2 Risk assessment and management

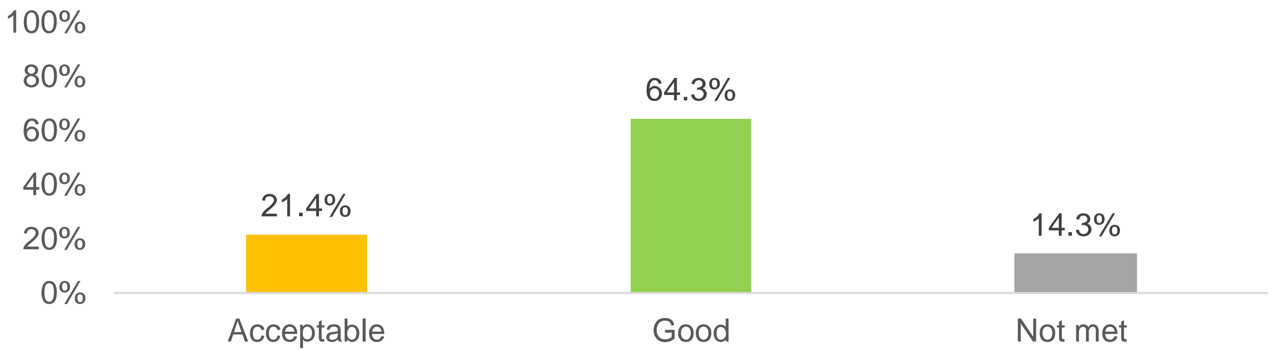
Table 2: Audit results for NSFT records by audit question.

Audit question	Acceptable	Good	Not met	Not applicable	Total applicable
6. There is a combined risk assessment, and management plan for the episode of care prior to discharge from the EIT. This has been reviewed within one year prior to discharge.	15	45	10	1	70
7. There is a record of the risk formulation in the person's health record	11	47	12	1	70
8. There is a crisis plan (within one year prior to discharge)	11	44	14	2	69

3. Findings (continued)

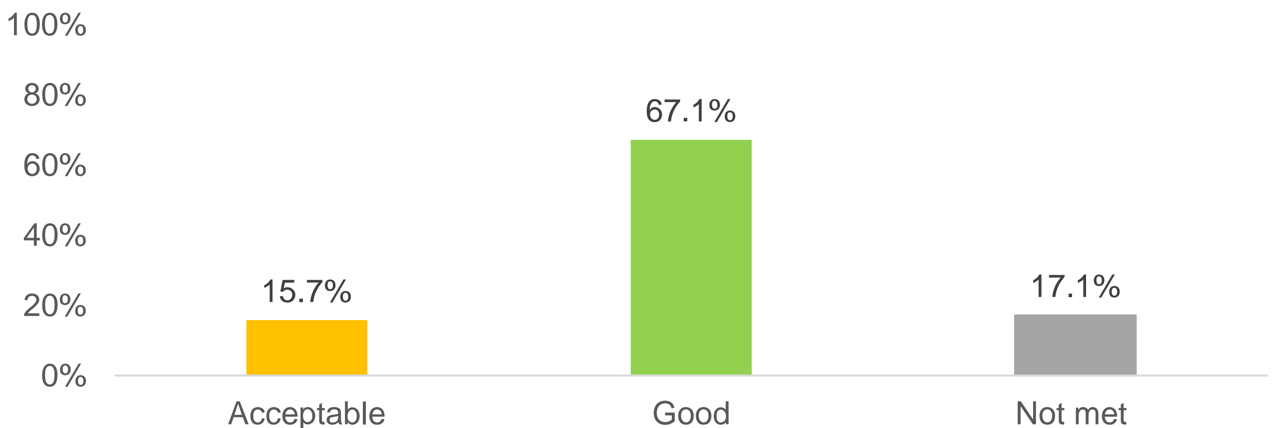
3.2 Risk assessment and management (cont.)

Chart 6: % of records classified as ‘Good’, ‘Acceptable’ and ‘Not met’ for question 6



There was evidence of good or acceptable combined risk assessments being available in 85% of cases. Where the response was ‘Not met’ there was a range of reasons for this including the last risk assessment being updated over 12 months prior to discharge from the EIT or patients who had not engaged at all with the EIT since referral. In four cases where ‘Not met’ was the finding, there were no reasons given or found in the case notes describing why this had not been possible.

Chart 7: % of records classified as ‘Good’, ‘Acceptable’ and ‘Not met’ for question 7

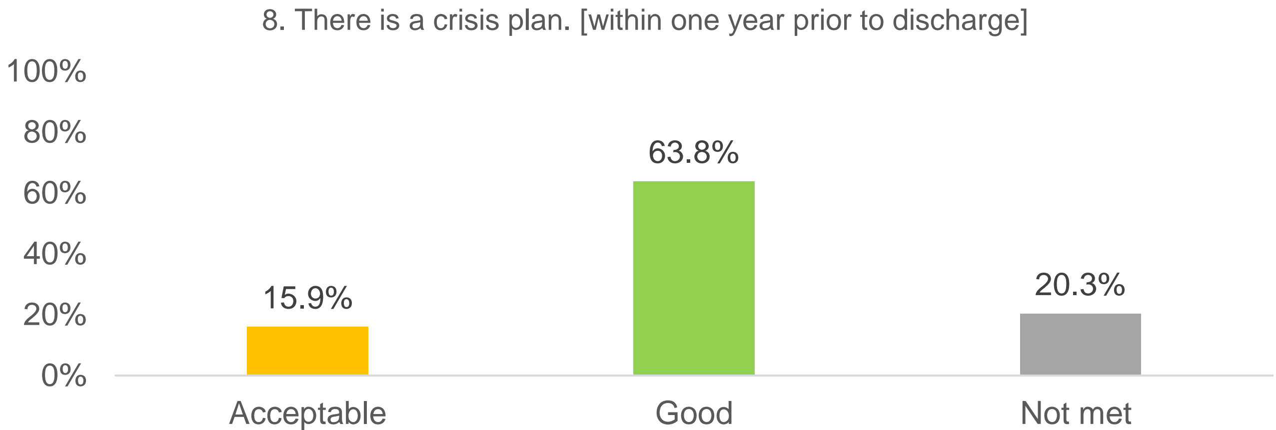


There was evidence of good or acceptable risk formulation assessments being available in 82% of cases. Where the response was ‘Not met’ the reasons align with Question 6 above, and this was primarily due to the last assessment and formulation being over 12 months old. In five cases, no clear risk formulation could be found within the electronic records during contact with the EIT.

3. Findings (continued)

3.2 Risk assessment and management (cont.)

Chart 8: % of records classified as 'Good', 'Acceptable' and 'Not met' for question 8



Crisis plans appeared in a range of locations in the electronic records including in 'staying well' plans, care planning documents or interim safety plans. For the records where the crisis plan could be identified, almost 80% were up to date (reviewed within three months of discharge) and over 60% had individual information to support the person and appeared to reflect the specific factors from their risk assessment. In 20.3% of cases, a crisis plan could not be found either within the three months prior to discharge or, in eight cases, there was no record relating to a crisis plan at all.

3.3 Discharge processes

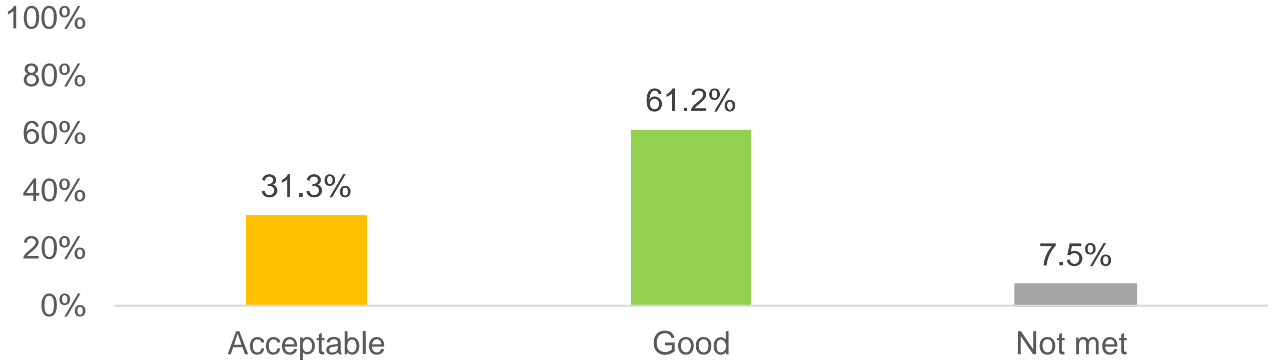
Table 3: Audit results for NSFT records by audit question.

Audit question	Acceptable	Good	Not met	Not applicable	Total applicable
9. There is a record of the involvement of the person and their family/carer (as appropriate) in discharge planning	21	41	5	4	67
10. There is evidence of discussion with members of the MDT and/or any others involved in the person's care prior to discharge	15	47	9	0	71
11. Information relating to discharge has been shared with the service user	8	42	19	2	69

3. Findings (continued)

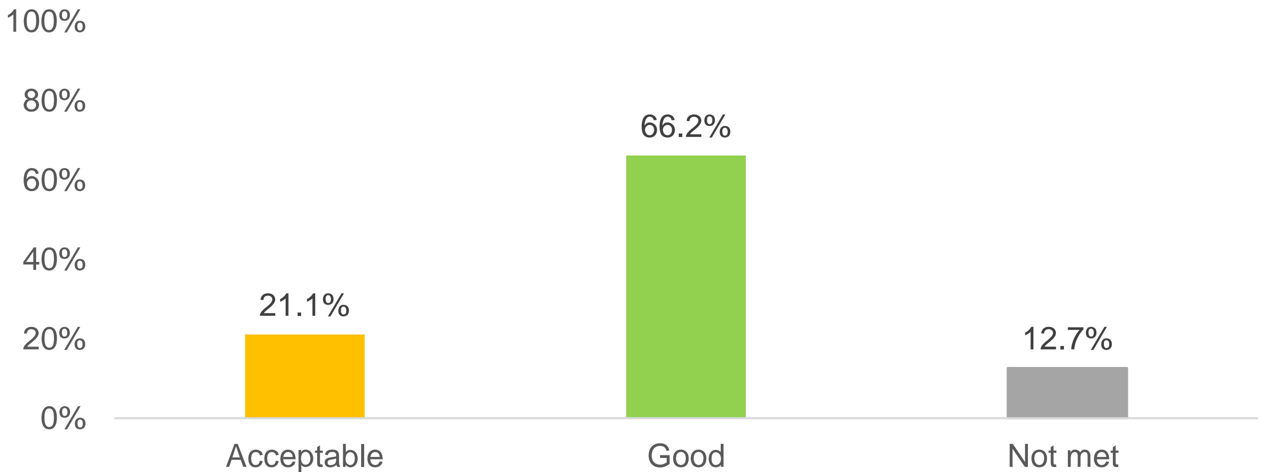
3.3 Discharge processes (cont.)

Chart 9: % of records classified as ‘Good’, ‘Acceptable’ and ‘Not met’ for question 9



In over 90% of cases, we found acceptable or good evidence of the involvement of the person and their family or carer (where appropriate) in discharge planning from the EIT. This included meetings to support planned discharge involving the patient or information about repeated attempts to engage where patients had chosen to stop engaging with the EIT. In the five cases where this was ‘Not met’, a valid reason could be found in all but one case (in which we could not locate any entry about discharge or handover).

Chart 10: % of records classified as ‘Good’, ‘Acceptable’ and ‘Not met’ for question 10

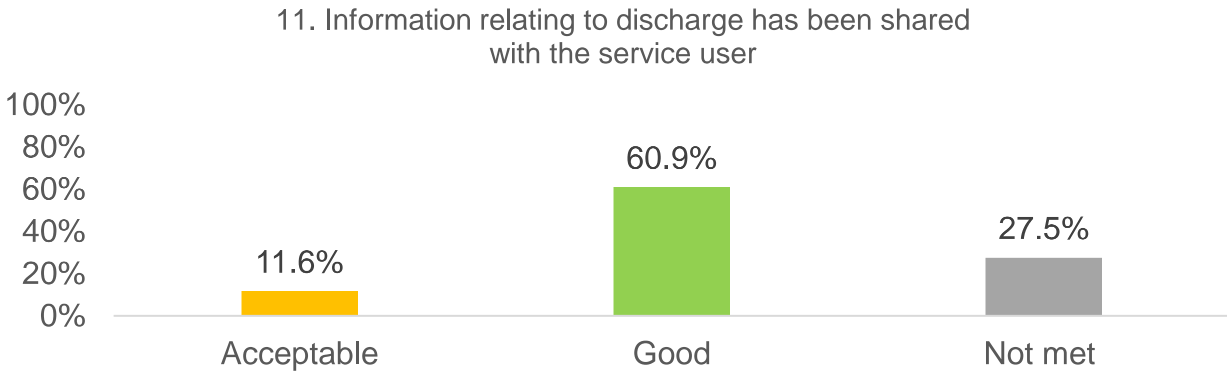


There were good or acceptable records of MDT discussions in the records reviewed relating to discharge plans. In some cases, this included full review and planning meetings involving several members of the team. In the nine cases where this was ‘Not met’, two cases had a clear rationale included in the entry. One patient was only assessed then discharged with a single lead professional involved rather than MDT; for a second patient who was on a ward, the MDT lead was the inpatient team. In seven cases, no clear entries could be found to provide a reason for a lack of MDT discussion.

3. Findings (continued)

3.3 Discharge processes (cont.)

Chart 11: % of records classified as 'Good', 'Acceptable' and 'Not met' for question 11



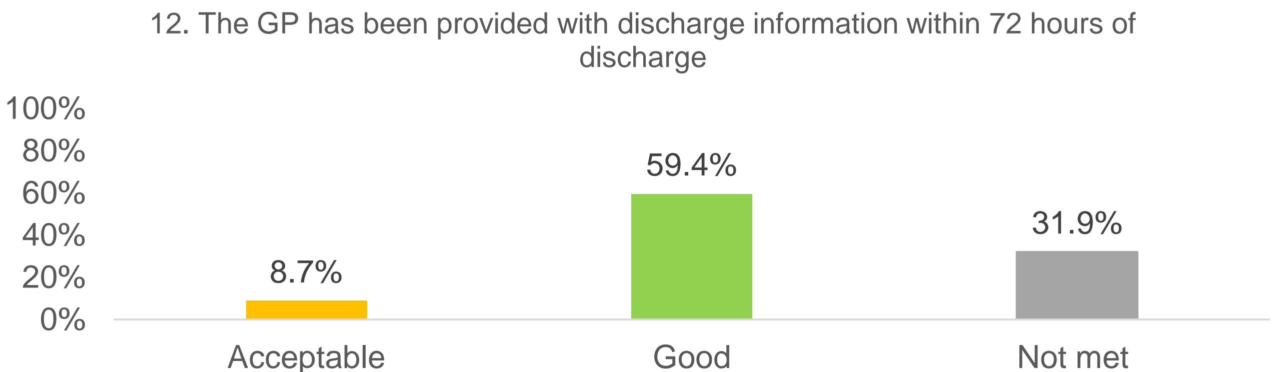
In 27.5% of cases, no record could be found of information being shared with the patient regarding the plan, actions or supporting information relating to their discharge from the EIT. In three cases, we found a record of telephone contact prior to discharge and information being shared verbally. In two cases, we could see that the patient was an inpatient or in prison. In all other cases, we did not find any indication of why the discharge information had not been offered in writing to the patient.

3.4 Sharing information with GPs

Table 4: Audit results for NSFT records by audit question.

Audit question	Acceptable	Good	Not met	N/A	Total (applicable)
12. The GP has been provided with discharge information within 72 hours of discharge	6	41	22	2	69

Chart 12: % of records classified as 'Good', 'Acceptable' and 'Not met' for question 11



In 68% of cases, we found evidence of a letter to the GP which contained a summary of care, treatment and progress with medications (if applicable), risks and information on how to seek further support or make a new referral to service. In 31.9% cases, no letter was found or, in the majority of these cases, this only offered minimal information that did not meet the minimum standards agreed for this audit. In one case of 'Not met', a letter was found but sent nine days after the discharge which was outside the specified time period of 72 hours.

3. Findings (continued)

3.5 Governance and quality systems

In this section, we have assessed the EIP service governance and quality systems, arrangements for identifying and escalating risks, and opportunities for improving the quality of services. Evidence to support this review was submitted separately from Norfolk and Waveney, and from Suffolk. We describe these arrangements below.

3.5.1 Norfolk and Waveney EIP governance arrangements

EIP teams have individual **Quality, Learning and Sharing Forums** which meet monthly. All team members are expected to attend and contribute. Each team has a quality improvement plan and a risk register. These forums report to the EIP Governance Meeting and Senior Leadership Team (SLT) Meeting, which also meets on a monthly basis.

The **EIP Governance Meeting and SLT Meeting** is responsible for overseeing the quality and safety of EIP services in Norfolk and Waveney (including the review, management and escalation of service risks). This forum undertakes a 'deep dive' into one item from the quality improvement plan (from team level) at each meeting. It is attended by clinicians, operational and team managers, corporate support services and allied health professionals. We note positively that commissioners and service users may also attend these forums.

A review of recent minutes and papers showed that this forum is broadly focusing on the areas which we would expect to see, including: patient experience, clinical audit, agreed quality metrics, risks, incidents, safeguarding and workforce matters. Information from the Trust's Quality Committee is shared here, which is also positive.

A summary report is then aggregated and shared at the **Specialist Services Care Group Governance** meeting by the Service Manager and Clinical Lead. The Care Group then reports to the **Trust Executive Team**, although the mechanism by which services and Care Groups report to the Trust's Quality Committee (and therefore the Board) is unclear.

3.5.2 Suffolk EIP governance arrangements

Both the East and West Sussex teams have **bi-monthly business meetings** which receive a governance report (including risk, patient experience and learning). As in Norfolk and Waveney, teams receive a bulletin called '5 Key EIP Learning Points'. This is a one-page summary to update staff on recent safety incidents, risks, patient feedback, service developments and audit outcomes. This is good practice, although we do not know how many staff read this information.

Suffolk EIP has a **Service Governance, Performance and Developmen**t monthly meeting, which lasts for 90 minutes. This is chaired by the EIP Service Lead, and should be attended by all Suffolk EIP staff. The scope of this forum is very broad to cover in one monthly meeting. It includes, for example:

- Service user feedback
- Caseloads and capacity and demand
- Workforce matters (including mandatory training, supervision and appraisal compliance)
- Risk management
- Operational policies
- Incidents and learning
- NICE guidelines compliance
- Quality improvement work

3. Findings (continued)

Two new forums are being implemented at county level in Suffolk, and we would expect that these will enable agendas to become more manageable. These are a monthly Countywide Governance Meeting and a monthly Countywide Quality Meeting. Terms of reference (ToR) for these meetings are currently in development.

Quality governance matters (including learning, risk and quality improvement) are also reviewed within the monthly Community Operational Meeting chaired by a Deputy Director and is attended by all Service Leads in West.

3.5.3 Risk management in EIP

Both Norfolk and Suffolk EIP teams have (separate) local risk registers which are reviewed in their respective governance meetings. There is evidence that these risk registers are used actively with some good examples of risk reduction, such as in relation to clinical supervision improvements.

The two EIT local risk registers do not use scoring such that it is unclear from reviewing the documents which risks are highest scoring, and what level they should be escalated to within the Trust (e.g. Care Group, Board level). Risks should have an initial, current and target score recorded to demonstrate the effectiveness of mitigating actions taken, and also to support risk appetite discussions.

These risk registers are live documents, held and managed locally. Corporately, the Datix system is used for risk management. This is an unusual arrangement and may mean a disconnect between information held at service level, and that known and being used in the Trust centrally. In most NHS trusts, Datix (or an equivalent system) is used at all levels, so that risks at a certain threshold trigger automatic senior review.

The Trust Risk Management Policy states that “more significant risks should be recorded on Datix”, and that “risks that subsequently cannot be managed within the team will be escalated to the Care Group via a Datix risk register entry”. There are potential problems with this approach, including that:

- multiple services could be facing similar risks which, albeit scored lower, require a corporate response but which the Executive Team and Board are unaware of;
- there is no central sense checking or quality assurance of service level risks, including scoring; and
- there is no automatic ‘trigger’ to the corporate risk register at a certain score.

Teams in both Norfolk and Suffolk report some similar risks; understaffing and a lack of structured service user engagement. These appear to be managed separately at present, and it is unclear how the strategic overview of EIP risk and management takes place.

3.5.4 Summary

There are elements of the EIP governance structure reviewed which are aligned to good practice, including:

- In both counties, there is a clear governance structure to support information flows and effective escalation. In Norfolk and Waveney in particular, this has been defined through to team level;
- Across the EIP service, there appears to be an expectation that all staff contribute to and engage in the governance agenda;

3. Findings (continued)

- Key learning points are sent to all staff on a monthly basis following governance meetings; and
- Risk registers at service level are clearly used, there are no examples of aged risks and there are some clear examples of positive risk 'movement'.

However:

- It is unclear why the two counties have adopted different governance structures. In our view, standardising agendas and terms of reference would enable more consistency of focus, and may lead to a more joined up response to common challenges across EIP; and
- Corporate risk management arrangements are unusual and, in our view, are unlikely to enable effective escalation. There is a possibility that the Trust Board does not have a clear line of sight into EIP risks, and that risk is not being managed in a joined-up, efficient way across the service itself.

3.5.5 Stability of staffing

Staff shortages in the Trust are well known and are recorded on the Board Assurance Framework in relation to Strategic Objective 1 – Ensuring Our Services are Safe; There are documented gaps in controls and assurances relating to "underlying cultural issues, safer staffing and retention of staff". The same document also outlines actions in place to address this, including the introduction of a safe staffing tool and a nursing establishment review. We do not know what the impact of these actions has been, nor how they affect the overall risk scoring. The CQC reported that processes in place to improve safe staffing (at a Trust level) had improved in its February 2023 report.

Board performance reporting (May 2023) shows that EIP access and wait times have exceeded the national standard and are performing above the national standard, since at least January 2021. This suggests that staffing is being managed well within the service. That said:

- A psychiatry post remains open in the West Norfolk team, and locum recruitment has been unsuccessful. This workload is currently being covered by psychiatry across the service, and by non-medical prescribing roles.
- We have been told that the service budget and staffing levels are below recommended levels according to PsyMaptic[6] predictive data; and
- Long waits for inpatient beds in both counties may mean that the service is holding higher risk patients on their caseloads.

The service level risk register for Norfolk shows that business support capacity in the service had been an issue, although the team is now fully staffed, and the risk has been closed.

See also learning point 2 at Section 4 of this report - over half of the cases we reviewed demonstrated that a consistent care coordinator or lead professional had been in place during the patient's contact with the EIP team. For some cases, this included contact over a number of years, offering evidence of some stability in staffing.

6 A population-level prediction tool for the incidence of first-episode psychosis. https://www.clahrc-cp.nihr.ac.uk/?page_id=5420

4. Recommendations

4.1 Learning points and recommendations

While completing the review, we aimed to identify opportunities for learning or improvement as well as areas of good practice. The table below sets out the learning points (both positive and where action is required) that have been used to inform the Trust's action plan shown at Appendix 1.

Audit question	Learning points/recommendations and good practice summary
Care, treatment and support	
1	Information relating to the care coordinator or lead professional was stored in different places in the electronic records system.
2	Over half of the cases reviewed demonstrated that a consistent care coordinator or lead professional had been in place during the contact with the EIT. For some cases, this included contact over several years, offering evidence of some stability in staffing.
3	In most cases, 'continuation notes' were used to review the last two encounters prior to discharge from the team. They were often found to be simple in structure, easy to access and provided clear accounts of contact, who would be the responsible lead and the next steps. Where patients had chosen to disengage from services, there were often several attempts made to contact the individual by telephone or home visit, including by different members of the MDT. Where patients had disengaged or refused any contact with the service, there was variation in the way individuals across the EIP teams were attempting contact.
4	The AMHP reports reviewed were found to be comprehensive and easy to access.
5	The recommendations made and (where found) the follow up notes input by medical staff when patients were admitted to an NSFT ward, were detailed and consistent in structure. These often included mental state, diagnosis and rationale for decision.
Risk assessment and management	
6	The Trust use Combined Risk Assessments which were often found in two different locations on the electronic records system. Risk information could also be found in other documents, for example Section 117 (MHA) plans for detained patients discharged by inpatient teams, which had not always been transferred to the combined risk assessment.
7	The risk formulations reviewed were variable across patient records. In some files, there was a clear and detailed entry made within the combined risk assessment. For others, the risk formulation used for the audit was taken from other documentation including care planning records or discharge letters to GPs. There was also variation in the way the risks were documented with different approaches to describing the seriousness of risk or exploration of individual protective factors.
8	Good practice examples of crisis plans were most often found in the 'staying well' format. The detail completed under the headings met or exceeded the minimum standard expected for crisis plans where a 'staying well' plan had been used.

4. Recommendations (continued)

4.1 Learning points and recommendations (cont.)

Question	Learning points and good practice summary
Discharge processes	
9	In most cases, it was easy to identify those occasions when the patient or their family had not been involved in the discharge process. However, there was not always an explanation or reason for this. For example, the record may have stated that the person did not engage but did not provide additional information to support the professional's understanding of why, or attempts made to support engagement.
10	The involvement of the MDT and level of information captured was variable. Good examples were particularly evident where there had been a full care planning or discharge meeting completed. This was often within a short time period before discharge (under a month in most cases). There was limited evidence found of discharge planning commencing in the six months before discharge, which could be an area for improvement.
11	Examples of very good discharge letters were found during the review. These included personalised details of the progress made during the person's time with the EIT, identifying and celebrating successes, and offering clear and compassionate support for continuing their recovery.
Sharing information with GPs	
12	Information provided to the GP varied between individual professionals and services. Good practice examples included where the EIT had transferred detailed information from the combined risk assessment or care planning documentation to the discharge letter. There were examples where the information appeared more limited due to short contact or assessment only with the EIT. However, in two cases reviewed, where the patient had limited contact, the lead professional had set out a detailed account of the reasons for the short duration of support, risk information they had been able to determine during the contact and a clear route of new referral if required.

Appendices

Appendix 1: EIP action plan

This section contains the action plans prepared independently by the NSFT EIP service in response to the findings of this audit. Niche has not quality assured its content nor made any judgements as to the appropriateness of actions identified.

Results				Observations	Action(s)	Completed by date
Good	**Accep-table**	**No**	**N/A**			
1. It is clear who the current care coordinator or the lead professional is at the point of discharge from the EIT.						
9	59	2	1	Continue to monitor through current monthly CPA audits.	No action needed.	
2. *If applicable:* **The health record includes details of any changes to the care coordinator or lead professional.**						
6	18	8	39	Utilise the Lead Care Professional role more than we currently do, for future.	Determine the process for changing Care Coordinator on Lorenzo and share with clinical administrators. Determine how to track these changes.	March 2023
3. Records relating to the last two encounters and/or interventions prior to discharge show who was involved and the outcome.						
11	124	2	5		No action needed.	
4. Where a Mental Health Act Assessment has taken place: **The assessment by the Approved Mental Health Professional is available in the health record.**						
1	36	1	33		No action needed.	
5. Where a Mental Health Act Assessment has taken place: **Details of the MHA assessment completed by doctors are available in the electronic health record.**						
3	33	2	33		No action needed.	

Appendix 1: EIP action plan (continued)

Results				Observations	Action(s)	Complete by date
Good	Accep-table	No	N/A			
6. There is a combined risk assessment, and management plan for the episode of care prior to discharge from the EIT. This has been reviewed within one year prior to discharge.						
15	45	10	1	We have developed a meeting where we review documentation, with view to chasing anything out of date. There are currently no formal 12-month CPA reviews in Suffolk due to lack of capacity, approx. 52% compliance. Reported through Governance structures and on risk register. Business case submitted in Suffolk to ensure CPA compliance.	Continue to monitor through monthly CPA audits. If no improvement, consider a quality improvement project. Build in new structures for more regular reminders of out-of-date data. Follow up on business case.	May 2023 May 2023 Sept 2023
7. There is a record of the risk formulation in the persons health record.						
11	47	12	1	Suffolk have completed DICES [risk assessment] training, as have several of Norfolk.	We have STORM training, which is being rolled out for the whole Trust. Include risk in future CPA audit.	6 months May 2023
8. There is a crisis plan (within one year prior to discharge).						
11	44	14	2	There is a checklist on Lorenzo for discharging patients.	Focus for Quality, Learning and Sharing Forums and Suffolk Governance meeting. To be included in CPA audit	May 2023 May 2023

Appendix 1: EIP action plan (continued)

<table>
<tr><th colspan="4">Results</th><th rowspan="2">Observations</th><th rowspan="2">Action(s)</th><th rowspan="2">Complete by date</th></tr>
<tr><th>Good</th><th>Accep-table</th><th>No</th><th>N/A</th></tr>
<tr><td colspan="7">9. There is a record of the involvement of the person and their family/carer (as appropriate) in discharge planning.</td></tr>
<tr><td>21</td><td>41</td><td>5</td><td>4</td><td></td><td>No action needed due to high score, however this may become part of a quality improvement project we have planned.</td><td></td></tr>
<tr><td colspan="7">10. There is evidence of discussion with members of the MDT and/or any others involved in the persons care prior to discharge.</td></tr>
<tr><td>15</td><td>47</td><td>9</td><td>0</td><td></td><td>No action needed.</td><td></td></tr>
<tr><td colspan="7">11. Information relating to discharge has been shared with the service user.</td></tr>
<tr><td>8</td><td>42</td><td>19</td><td>2</td><td>One discharge letter is needed, sent to Service Users and copy to GP.</td><td>Service User focus group are working on a discharge pack, needs following up.

Carry out discharge audit. Assistant Psychologists / Peer Support workers can help to collate qualitative data across Norfolk and Suffolk.</td><td>April 2023

Feb 2024</td></tr>
<tr><td colspan="7">12. The GP has been provided with discharge information within 72 hours of discharge</td></tr>
<tr><td>6</td><td>41</td><td>22</td><td>2</td><td>[This timeframe] has been changed to one week, following ratification from Quality committee.

Care Coordinator does letter to GP. Letter from Doctor can follow.</td><td>Review discharge policy, review discharge letter and clarify who completes this.</td><td>May 2023</td></tr>
</table>

Appendix 2: Audit tool

Date of audit	
Service	
Name of Niche staff member conducting the audit	
Niche assigned patient number (not NHS number)	
Date episode with the EIT began	
Date of discharge	

Question	Acceptable evidence	Good evidence
Care, treatment and support		
1. It is clear who the current care coordinator or the lead professional is at the point of discharge from EIT	The health record identifies the correct current care coordinator or lead professional. This may be specified in referrals, care plan or combined risk assessment	The record identifies date of first involvement with the person
2. *If applicable:* The health record includes details of any changes to the care coordinator or lead professional	Changes to the care coordinator or lead professional are identifiable in the health record	The combined assessment is up to date at point of transfer, and this includes a safety plan that informs the support needed from the new lead or care coordinator.
3. Records relating to the last two encounters and/or interventions prior to discharge show who was involved and the outcome	The record reflects what took place, names and roles of staff involved. The record includes details of the outcome of the intervention or assessment.	Any next steps or actions are specified with leads assigned.
4. *Where a Mental Health Act assessment has taken place:* The assessment by the Approved Mental Health Professional is available in the health record	The assessment or social circumstances report has been uploaded to the electronic health record.	The assessment includes the AMHP opinion, risks and supporting information. This would include any assessment that did not lead to the MHA being used.
5. *Where a Mental Health Act assessment has taken place:* Details of the MHA assessment completed by doctors are available in the electronic health record	The record only partially reflects the requirements defined in 'good' – see bullets opposite. For doctors who do not work for NSFT, their written summaries have been scanned or entered into Lorenzo by NSFT staff	The NSFT psychiatrist(s) has recorded their findings of the assessment, and these include: • mental state; • Diagnosis; and • rationale for decision.

Appendix 2: Audit tool (cont.)

Question	Acceptable evidence	Good evidence
Risk assessment and management		
6. There is a combined risk assessment, and management plan for the episode of care prior to discharge from EIT. **This has been reviewed within one year prior to discharge.**	The risk assessment includes: • the reasons for assessment; • key risks; and • who has been involved in the assessment. The management plan contains individual information including the views of the service user and their family (or reasons for this not to be included). There is information on the services user's life, situation, strengths and protective factors	The risk assessment specifies each individual risk factor and the impacts for the person and their situation.
7. There is a record of the risk formulation in the person's health record	The risk formulation addresses: • how serious the risk is; • how immediate the risk is; • If risk is specific or general; • how volatile the risk is; • the signs of increasing risk; and • the treatment, and management plan, that will best reduce the risk	The risk formulation also includes information on: • personality; • history; • mental state; • environment, • potential causes; • protective factors; and • changes in any of these.
8. There is a crisis plan **(within one year prior to discharge)**	The plan is up to date (reviewed within the previous three months before discharge).	The plan reflects individual information and supporting information based on the combined risk formulation and management plan. It is clear how the service user has been involved in the development of the crisis plan and can access further support
Discharge processes		
9. There is a record of the involvement of the person and their family/carer (as appropriate) in discharge planning	There is evidence that contact was made within six months before discharge with the service user and/or family member/carer. Their views, including if they did not wish to engage with the discharge process, are available in the record. Where there is no family/carer involvement evidenced, there is information to explain this.	Discussion and decisions are recorded with any questions, concerns or issues stated in the record. There is information on how to maintain the service user's wellbeing, and the steps to take in the event of a crisis have been shared with the person and their family/carer (as appropriate).

Appendix 2: Audit tool (cont.)

Question	Acceptable evidence	Good evidence
Discharge processes		
10. There is evidence of discussion with members of the MDT and/or any others involved in the persons care prior to discharge	There is evidence of inter-agency communication. This took place within six months before the planned discharge date. *Where applicable:* If discussed during a formal MDT meeting, there is a summary record of the discussion and the outcome.	There is evidence in the health record of the involvement of, and information shared with, people involved in the person's care. The notes identify: • individual roles in care; • their views on discharge; and • any concerns or issues raised.
11. Information relating to discharge has been shared with the service user	A letter (in any format) has been sent to the service user which summarises information on the plan, actions, and prescribed medication. It refers to other supporting documents e.g. care plan, crisis plan, but does not include full detail in the letter.	The letter includes individual information relating to: • service user's plan for managing their health; • what the service user/others can do and who to contact if their health worsens or they experience a crisis; and • information about prescribed medication.
Sharing information with GPs		
12. The GP has been provided with discharge information within 72 hours of discharge	A letter has been sent to the GP and stored in the electronic records. This includes: • a summary of care, treatment and progress; • medications prescribed and monitoring required; • known risks; and • advice on how to make a new referral.	The letter includes information relating to: • a summary of care and treatment/interventions and progress, diagnoses and ICD10 codes, medications prescribed, monitoring required, any physical health conditions and ongoing treatment/monitoring needs, known risks and risk management. • Clearly states any concerns and/or consequences of non-adherence with medication.

Appendix 3: Schedule of documents reviewed

- Care Group Assurance Reports (various)
- Diagram showing risk escalation process within the trust (un-named and undated)
- Discharge from Trust services [framework] – Summary of key points (March 2023)
- EIP service - Governance structure and feedback loop
- Guidance regarding record keeping and communication following mental Health Act assessment by NSFT psychiatrist (undated)
- Internal review [report] of the care and treatment of the service user (SU1) who was convicted of the murder which occurred on the 5th August 2017
- Local Risk Register (EI Service)
- Minutes and papers for Norfolk and Waveney Specialist Services EIP Clinical Governance Meeting – November 2022
- Norfolk and Waveney Youth Operational Policy (undated)
- Patient Safety and Patient Safety Investigations Policy (2022)
- Quality and Performance Governance Report - Norfolk and Waveney Specialist Services - June 2022
- Risk Management policy (November 2021)
- Serious incident early learning summary reports and 'Five key learning points'
- Specialist Services Quality and Performance Meeting report (April 2021)
- Terms of reference - EIP Governance meeting (January 2023)

The Review Team also received and reviewed various email trails describing actions taken relating to this serious incident. We have not listed these emails in this appendix unless there was specific evidence attached to the correspondence.

Appendix 4: Glossary

AMHP	Approved Mental Health Professional
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CRHTT	Crisis Resolution Home Treatment Team
CTL	Clinical Team Leader
(EI)P	(Early Intervention) in Psychosis
MDT	Multi-Disciplinary Team
MHA	Mental Health Act 1983
NSFT	Norfolk and Suffolk Foundation Trust

insight
integrity
impact

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