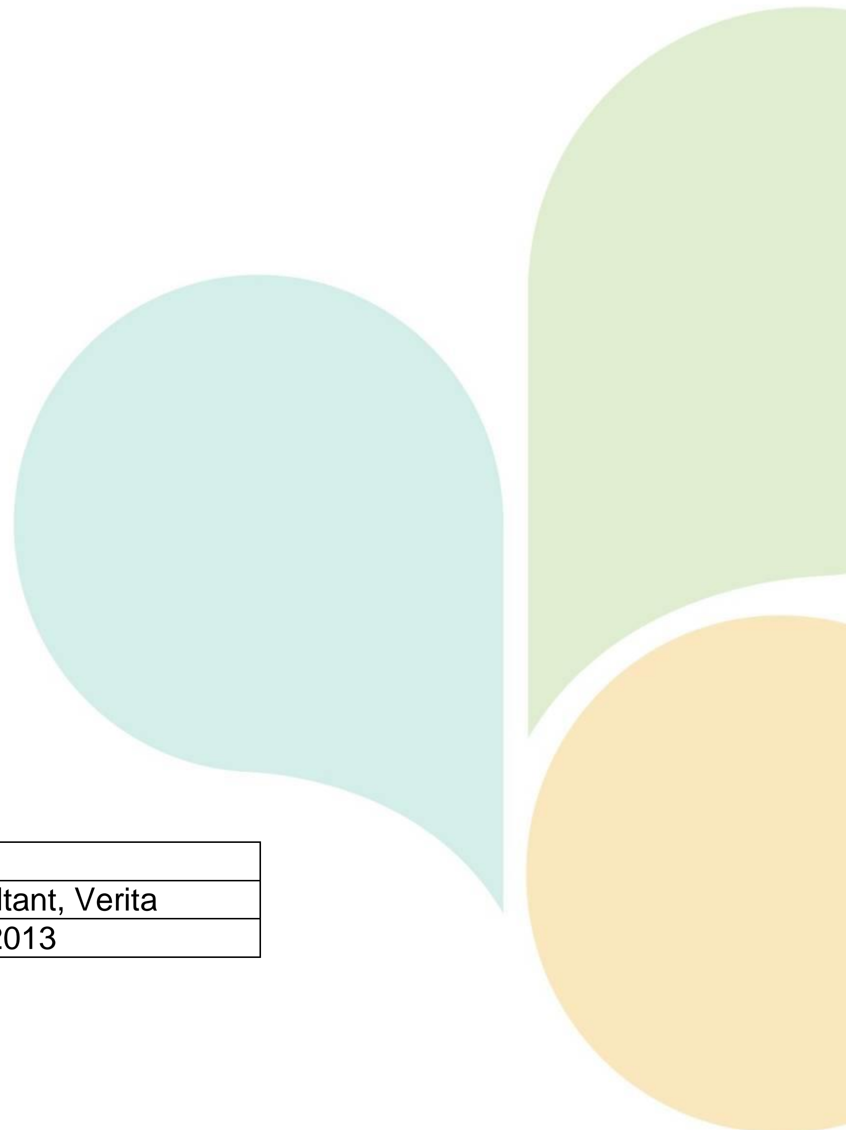
Central and North West London NHS
NHS Foundation Trust

# CONFIDENTIAL

# Serious Incident Investigation Report



| Author | Tariq Hussain |
|---|---|
| Job title | Senior Consultant, Verita |
| Date report completed | 5 November 2013 |

We would like to extend our sincere condolences to the victim's family and apologise for the distress this sad event has caused them.

Andy Mattin
Executive Director of Quality and Nursing

# 1 Investigation Overview

| Incident date | Incident type | Healthcare speciality |
|---|---|---|
| 10/07/2013 | Homicide | Mental health |

## 1.1 Incident description & consequences

Trust staff found out from a press report that Mr. S had been arrested on 10 July 2013 and charged with the murder of his wife. The press reported the cause of death as compression of the neck.

## 1.2 Severity level

5

## 1.3 Pre-investigation risk assessment

| A - Potential severity level | B - Likelihood of recurrence | C - Risk rating (A x B) |
|---|---|---|
| 5 | | |

## 1.4 Background and context

Mr. S GP referred him to Trust services on 24 January 2013. The Trust's assessment and brief treatment team (ABT) assessed him that day and referred him to the home treatment team (HTT). They assessed him on 25 January and accepted him into the service. He stayed with them until 28 February when they referred him back to the ABT to be seen by their consultant in outpatients. Mr. S did not engage with the team and was discharged back to the care of his GP on 5 July. A private psychiatrist saw him while he was involved with Trust services.

**Principle diagnosis:** Recurrent depressive disorder, current episode with somatic syndromes. ICD: F33.11

**Last risk assessment:** 28/02/2013

**Last CNWL care plan:** 28/02/2013

# 2 Investigation approach

## 2.1 Terms of reference

- The development of a chronology of events to assist in the identification of any care and service delivery problems leading to the incident.
- An examination of the mental health services provided to Mr. S and a review of the relevant documentation.
- The extent to which the care provided to Mr. S by CNWL was in accordance with statutory obligations, relevant national guidance from the Department of Health, including local operational policies.
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs.
- The exercise of professional judgment and clinical decision making.
- The appropriateness and quality of risk assessments.
- The effectiveness of interagency working with particular reference to the sharing of information between Mental Health Services and other agencies, including the Police and Local Authority, as appropriate.
- Consider other such matters as the public interest may require.
- Complete an Investigation report for presentation to the Trust.

## 2.2 Investigators

| Name | Title |
|---|---|
| Name: Bhavana Desai | Title: Chair & Trust non-executive |
| Name: Ann Sheridan | Title: Head of Social Work and Social Care |
| Name: Dr Mo Zoha | Title: Consultant Psychiatrist |
| Name: Peter Walsh | Title: Director of Nursing Practice |
| Name: Mr T Hussain | Title: Verita, External Facilitator |

## 2.3 Documented evidence reviewed

Clinical notes; clinical letters and assessments

## 2.4 Families contacted

We wrote to Mr. S family and his wife's family via the police and offered to meet them. The police advised that, following advice from the Crown Prosecution Service, the letters will not be passed on until after Mr. S trial, scheduled for January 2014. The ABT team manager told us she and the consultant tried to contact the families after hearing about the incident.

## 2.5 Interviews

We interviewed:

- nine clinical members of the ABT and HTT who were directly involved with Mr. S
- the HTT and ABT managers
- the HTT and ABT consultant psychiatrists

## Chronology of the care and treatment of Mr. S

### 2.6 24 January 2013

Mr. S GP saw him and his wife that morning. Mr. S had left early for work but had ended up pacing up and down a tube station platform contemplating jumping in front of a train. He was feeling low and had been worrying about his finances for the previous two to three months.

Mr. S wife told the GP he had left his wedding ring at home and planned to commit suicide.

Mr. S GP noted he was feeling low and tearful but had had no previous issues with his mental health. The notes say he was usually stable and had been happily married for over 10 years.

Mr. S GP referred him to the H assessment and brief treatment team (ABT). An ABT duty worker saw him the same day to assess his risk. The ABT duty worker referred Mr. S on to the home treatment team (HTT).

A worker from the HTT contacted Mr. S that day and arranged to assess him the next day.

### 2.7 25 January 2013

An HTT worker assessed Mr. S at home. Mr. S wife was present. The clinical records show he appeared depressed and had felt suicidal for 15 days. Mr. S attributed this state to pressures at work and fear of redundancy and he was preoccupied with the idea he had let his family down.

The HTT worker risk assessed Mr. S. Mr. S reported regretting his suicidal ideas and said his family was a strong protective factor. No evidence of risk to himself or others was identified during the assessment.

### 2.8 27 January 2013

The HTT worker visited Mr. S at home. Mr. S wife was also present. Mr. S reportedly engaged well with the HTT worker throughout the visit. He reported no suicidal or homicidal thoughts. His wife was keen for him to see the HTT doctor. Staff from the HTT told her this had already been planned.

### 2.9 28 January 2013

Records show the HTT consultant psychiatrist planned to review Mr. S the next day. The consultant reviewed the case notes in preparation for the visit.

An HTT worker visited Mr. S again at home. He was seen alone initially and then with his wife. The HTT worker thought his mood was low but Mr. S reported some improvement in his mental state. He was preoccupied with pain in the left side of his body.

The HTT worker reported that the patient's wife was worried. They had seen a GP at Mr. S practice (not his usual GP) that morning because Mr. S reported physical pain. The GP found no physical abnormalities and thought the pain was psychological. The GP prescribed diazepam, which Mr. S wife planned to administer. Mr. S expressed no self-harm, suicidal or homicidal thoughts, intent or plans to harm himself or others during this visit.

**2.10 29 January 2013**

The HTT consultant psychiatrist saw Mr. S alone at home as planned. The consultant noted Mr. S mood was low because of stress at work and because a junior colleague was receiving a bigger bonus than he was. He had also started to experience pain and weakness in his left arm and leg. He said his father suffered from motor neurone disease and he was concerned he would too.

Mr. S admitted to suicidal thoughts but after input from the HTT, these feelings had lessened. He said his wife was supportive. He denied intent to harm himself or others. He was sleeping badly and suffered from sleep apnoea (interrupted breathing during sleep).

The records show Mr. S was waiting for an appointment with the neurologist and the results of various tests.

Mr. S had also seen a private psychiatrist the week before because he felt unable to wait to see the HTT consultant psychiatrist. The HTT consultant thought Mr. S appointment with the private psychiatrist was a one-off. We found no NHS record of the outcome of the private psychiatrist's consultation.

The HTT consultant discussed medication with Mr. S. The HTT consultant discussed the diagnosis of a depressive disorder with psychosomatic symptoms with him. They agreed it would be best to wait for the results of his tests before starting more prescriptions, because there could have been a physical cause for his pain and weakness.

They spoke about his job. Mr. S worked long hours as an accountant. His wife was an occupational therapist and had recently gone back to work after maternity leave. His daughter was being looked after in nursery.

Mr. S felt his wife was supportive but she sometimes became frustrated with him because she could not understand what was going on with him. They had been married for over ten years and were happy. The HTT consultant asked him about alcohol misuse. Mr. S said he would have a glass of wine with his dinner but denied excessive use.

Mr. S told the HTT consultant he enjoyed cooking and spending time with his family; he said he was a family man. His extended family were in India but he was close to them.

Mr. S was happy to continue with HTT support and for their consultant to review his medication when they had the results of his tests.

Mr. S engaged well with the HTT consultant. He was preoccupied about his pain and weakness but accepted depression might have caused it. His wife attended some of the visits and was aware of his care plan. The HTT consultant decided that the HTT would see Mr. S daily.

**2.11 30 January 2013**

A worker from the HTT saw Mr. S at home. His mental state appeared stable but he still complained of pain in his left side. Mr. S told the member of staff his GP had referred him to a neurologist who had seen him.

A worker from the HTT saw Mr. S the next day at home with his wife Mr. S reported continuing sleep problems and intense pain in his left side.

Only zopiclone (assists with sleeping) had been prescribed at this point because the results from Mr. S recent MRI scan had not been reported. Mr. S and his wife contacted the HTT consultant because they were anxious for Mr. S to start treatment. The consultant advised Mr. S to stop taking zopiclone, to start taking duloxetine 60mgs (antidepressant) in the mornings and to use promethazine 50mg (sedative) if needed.

The HTT worker noted no psychotic symptoms during the review and Mr. S mood was reported as stable. Mr. S expressed no suicidal or homicidal thoughts and said that his wife was supporting him well.

**2.12 1 February 2013**

An HTT worker tried to visit the patient at home as planned but he was out. Mr. S later rang the HTT to say he was feeling better and had gone for a walk.

**2.13 2 February 2013**

An HTT worker visited Mr. S. He was with his wife and young daughter. He denied feeling low but was frustrated with the pain. He was still not sleeping well. He expressed no self-harm, suicidal or homicidal thoughts and alternate day visits were discussed.

**2.14 4 February 2013**

The HTT consultant psychiatrist reviewed the case. She noted low risk, suggested the HTT visit him less often and that Mr. S should be considered for discharge next week.

**2.15 5 February 2013**

An HTT worker visited Mr. S home but he was out. Mr. S called the team later. He said he was still concerned about the pain in his left side and about his medication. An HTT worker agreed to visit Mr. S the next day.

**2.16 6 February 2013**

An HTT worker visited Mr. S and saw him without his wife. He noted Mr. S mood was low. Mr. S said he was feeling down because of physical pain. He

decided to continue with his prescribed medications. The HTT worker did not identify any risk.

**2.17 8 February 2013**

An HTT worker saw Mr. S and his family at home. He was still preoccupied with the pain in his left side. He had seen a private psychiatrist for the second time who had added pregabalin 75mgs twice daily (used for anxiety and neuropathic pain) to his medication regime. He reported his mood was OK. He spoke of his wife's support and said she had been a great source of strength for him. He was desperate to get back to work but did not feel well enough.

**2.18 9 February 2013**

An HTT worker visited Mr. S at home but he was asleep so he talked to Mr. S wife. She was frustrated he was not making progress and said this was causing problems in their relationship. She said he had seen both a private psychiatrist and a private neurologist. The NHS has no record of the outcome of these appointments. The HTT worker recorded that Mr. S mother planned to visit from India. A week's worth of Mr. S prescribed medication was left with his wife.

**2.19 11 February 2013**

An HTT worker visited the patient without his wife. Mr. S said his mental state had improved and the pregabalin had reduced the pain in his left side. He reported his sleep and appetite had improved. The HTT worker identified no risks during this assessment.

**2.20 13 February 2013**

An HTT worker visited Mr. S. He was seen alone again. He reported continued improvement in his mental state. He was due to see a private psychiatrist the following morning and reported his MRI and blood results were normal. His mother was expected to arrive on 15 February 2013.

**2.21 16 February 2013**

An HTT worker visited Mr. S and his wife at home. He said he had improved but not as much as he would like. He and his wife asked for an increase in medication. The HTT worker advised Mr. S to discuss this with the HTT consultant psychiatrist during his next review. His wife confirmed he had improved but also said she was angry with him at times because he could not do much around the house. She spoke positively about his mother staying with them and about her help. We found no record of Trust staff having met the Mr. S mother.

**2.22 18 February 2013**

An HTT worker visited Mr. S at home. He presented as stable and denied suicidal thoughts. He was more optimistic for the future. He said he would see a private psychiatrist again. The HTT worker agreed to visit the next day

because Mr. S was due to see his work's occupational health department on 20 February 2013.

**2.23 21 February 2013**

An HTT worker visited Mr. S at home. Mr. S said he felt better and that medication had helped him a lot. He said his mood, sleep and appetite had improved. The HTT worker identified no risks.

**2.24 23 February 2013**

An HTT worker dropped some medication off at Mr. S home. A review with the HTT consultant psychiatrist was scheduled for 25 February 2013.

**2.25 25 February 2013**

The HTT consultant reviewed Mr. S with his wife as planned. The consultant noted Mr. S had improved since starting medication, Mr. S and his wife agreed. Mr. S wife talked a lot but Mr. S was passive. She said she did not know much about mental illness and at times would get angry with Mr. S. She felt he did not tell her how he was feeling which made her frustrated and angry. She then started crying and said she was reading about depression to understand it better. She was keen for Mr. S to go back to work.

She said Mr. S was doing more at home and was engaging better with their daughter.

The HTT consultant talked about Mr. S medication and the need for input from a psychologist, the couple agreed. Mr. S was referred to improving access to psychological therapies (IAPT) the next day.

The HTT consultant talked to Mr. S and his wife about his recovery; the need for Mr. S to get back to his normal routine but also not to rush himself. He was ambivalent about the cause of his pain, and still thought it was physical, rather than psychological.

Both Mr. S and his wife felt Trust staff had listened to and supported them and they were happy with the outcome of the consultant's review.

An HTT worker also visited Mr. S on 25 February. He noted Mr. S felt better mentally and agreed to discharge him from the HTT on 28 February 2013.

**2.26 28 February 2013**

An HTT worker visited Mr. S at his home. Mr. S was noted to be in a positive mood. He was discharged from HTT with a plan for the assessment and brief treatment team (ABT) to follow him up.

**2.27 1 March 2013**

The ABT triaged the HTT referral.

**2.28 5 March 2013**

The ABT agreed an outpatient appointment plan: to discharge Mr. S if his mental health remained stable.

**2.29 11 March 2013**

Mr. S phoned the ABT to cancel an appointment with their consultant psychiatrist scheduled for 16 May. The ABT offered him a new appointment for 23 April, which he also cancelled. We found no reason for the cancellations in the clinical records. A new outpatient appointment was offered for 27 June but had to be rearranged and was offered for 1 July 2013.

**2.30 2 May 2013**

Mr. S saw his GP. The notes say that they spoke about "*human resources issues, possibly being bullied at work*".

**2.31 13 May 2013**

The Trust's IAPT psychological therapies service wrote to Mr. S GP to say that Mr. S had not attended an appointment with the cognitive behavioural psychotherapist on 23 April 2013. Mr. S had not responded to a follow up letter from the service and they closed the case on 10 May because of Mr. S non-attendance.

**2.32 1 July 2013**

The ABT consultant psychiatrist called Mr. S and left a message asking him to call back because he had not attended his outpatient appointment.

**2.33 2 July 2013**

Mr. S did not call back and the consultant tried to contact Mr. S again without success.

**2.34 5 July 2013**

The ABT consultant reviewed Mr. S case notes. He decided to refer Mr. S back to his GP because Mr. S had been stable when the HTT discharged him.

**2.35 10 July 2013**

Mr. S was arrested and charged with the murder of his wife. Paramedics treated her at home but she died later at H hospital. The press reported the cause of death was compression of the neck.

**2.36 18 July 2013**

The ABT consultant psychiatrist did not know Mr. S had been charged with murder and sent a closure letter to Mr. S GP. The team found out about the alleged murder when a team member read about it in the press and remembered the name.

# 3 Themes arising from the chronology

## 3.1 Assessments

Trust staff completed several assessments and discharge summary plans. We set out a table of them below including information about how complete they were.

| Date | Assessment | Information |
|---|---|---|
| 24 Jan | Initial assessment by ABT nurse | All relevant sections completed.<br>Section 15, (provisional care plan-actions and arrangements) notes discussion with the duty senior and team doctor. The plan was to refer the patient to HTT for closer monitoring. |
| 24 Jan | Risk assessment by ABT nurse | Front page section 1 completed and section 2 Risk history. No risk plan. |
| 25 Jan | Crisis resolution outcome of assessment form by HTT nurse manager | Single sheet form with basic name and address details and documented that Mr. S was accepted on to the case load by HTT. |
| 25 Jan | Bromley screening tool by HTT nurse | A substance misuse and alcohol use assessment tool. No problems identified: minimal alcohol use, no drug use. |
| Date not known | Clustering-author not known | In section 7 (problems with depressed mood) Mr. S scored as moderately severe. All other sections scored as "*no problem*". Section 2 (non-accidental self-injury) was also scored as no problem. This is wrong because he was a suicide risk. |
| 25 Jan | Risk assessment by HTT nurse | A new risk assessment but consistent with the one the ABT nurse made the previous day. |
| 25 Jan | Care plan-CRT/A&E liaison team by HTT nurse | Single sheet care plan identifies Mr. S problems<br>**Goal**: To stabilise mental state<br>**Actions**<br>• Daily visits to monitor mental state and risk.<br>• HTT doctor to review as soon as possible.<br>• HTT to support with relaxation techniques.<br>• For Mr. S to call the crisis line if unable to cope outside arranged visits-crisis number given.<br>• HTT to liaise with GP and ABT. |
| 27 Feb | Discharge notification by HTT speciality doctor | Mostly documents medication information, also records Mr. S diagnosis as "*recurrent depr dis, curr epi with somatic syn: (Primary Diagnosis)*". |
| 28 Feb | Discharge summary/plan by HTT nurse | Progress and interventions section shows the team felt Mr. S had improved:<br>• Much brighter in mood.<br>• Reported to be feeling less anxious.<br>• Sleeping better with the aid of promethazine.<br>• Appetite has improved.<br>• No suicidal thoughts reported upon questioning at the time of discharge. |

| | | • No suicidal thoughts reported upon direct questioning at the time of discharge.<br><br>Care plan: discharge Mr. S to ABT plus a number of other actions. |
|---|---|---|
| Date not known | HONOS author not known | Completed, two sections of note:<br>• section 1 (overactive, aggressive, disruptive or agitated behaviour)- Mr. S scored as having ***"minor problem requiring action"***; and<br>• section 7 (problem with depressed mood)- Mr. S was assessed as having "***mild problem but definitely present"*****.** |
| 28 Feb | Risk assessment by HTT nurse | Page 1 and 2 completed as a discharge risk assessment |

In general, these assessments were made competently and comprehensively. They were made on time and identified key issues and risk factors. Information from Mr. S wife was included in some of the assessments.

**Finding 1**

**Most assessments the ABT and HTT made were completed competently.**

## 3.2 First involvement of the assessment and brief-treatment team (ABT)

ABT were first involved with Mr. S when his GP referred him to them on 24 January 2013. ABT referred him to the HTT based on assessments they made that day.

The summary of the initial assessment made by the ABT says:

> *"1 Depressed with all clinical symptoms and including suicidal ideation and previous active plans and intent- (yesterday)*
> *2 Needs medication to help mood and sleep- Mr. S is agreeable to this*
> *3 Financial worries"*

Mr. S visited his GP with his wife on 24 January 2013 having contemplated jumping in front of a train the previous day. The initial risk assessment conducted by the ABT identified he did not jump onto the railway lines because it disturbed him and he returned home. He agreed to take medication after the ABT assessment. The assessing nurse discussed it with the duty senior and the team doctor and decided to refer him to the HTT.

***Comment***

***The decision to refer Mr. S to the HTT was reasonable given his presenting symptoms and assessed risk factors. Admission as a voluntary patient or sectioning him under the mental health act would have been inappropriate because his wife was supporting him, he was in contact with his GP and intensive support from the HTT would have been suitable.***

**Finding 2**

**The decision to refer Mr. S to the HTT was made in good time and was the correct judgement based on the assessment of Mr. S and consultation with senior colleagues.**

### 3.3 Home treatment team care

The ABT team referred Mr. S to the HTT on 24 January 2013. The HTT contacted him that day and offered him an appointment the next day. As the table of assessments above shows, the HTT team conducted several assessments and completed a care plan.

From 25 January to 28 February the patient was:

- Visited at home 17 times, including two clinical review visits the team consultant psychiatrist made. A number of these visits included discussion with Mr. S wife;
- called by a HTT worker twice because he was not at home when staff visited; and
- Reviewed (with his wife) at the Riverside Centre by the team consultant psychiatrist.

Staff completed entries on JADE after visiting Mr. S. We reviewed all the JADE notes and found staff were alert to deterioration of Mr. S mental state or increased risk. The entries also show alternative treatment options were considered. Mr. S agreed to be referred on 25 February for cognitive behavioural therapy with the improving access to psychological therapies (IAPT) service.

We include two entries as examples of the quality of the JADE note entries. A community psychiatric nurse (CPN) made the entry below after visiting Mr. S on 6 February 2013:

> *"Home visit to [Mr. S] this morning together with student nurse… He was pleasant on approach and welcoming. He was alone at home. He was dressed in his nightclothes. He was calm, relaxed made good eye contact and engaged well in conversation. He is still complaining of physical pain and not sleeping properly. Expressed of feeling down due to physical pain. Objectively he appeared slightly low in mood. Stated that he has neurological appt and MRI scans coming up soon. Basic counselling offered. Said his mother is coming soon to help out. Advised him to continue his medication as prescribed. He complained of feeling nauseous for the first two days then said the symptoms has improved. Reported of eating well. No psychotic symptoms elicited. No self harm/suicidal/homicidal thoughts, intent or plan expressed. Encouraged to use HTT pager number in moment of crisis.*
>
> *Plan-HTT to visit on Friday 08/02/2013 between 10.00-12.00hrs."*

A different CPN made the following entry after a home visit on 21 February 2013:

> *"[Mr.S] was dressed appropriately with good eye contact. Good self care observed. Reported feeling much better in himself. Much brighter in mood. Stated that the medication has helped him a lot. Described his mood as improved. Affect: Reactive. No psychotic symptoms elicited. Much calmer in himself. Stated that he has been setting some tasks to add structure to his day. Reported good sleep and appetite. No suicidal thoughts reported upon direct questioning. Requested some medication. Stated that he has not pregabalin left for 22/2/13 in the morning. Requested to the team to drop it off in the morning. [Mr.S] was informed of the appointment with [team consultant psychiatrist] at 15.30 on 22/2/13.*
>
> *Plan: HTT to order medication and drop it off on 22/3/13-am-has no morning meds."*

**Finding 3**

**The frequency of visits, support provided and quality of notes HTT made during Mr. S involvement with them were suited to Mr. S needs and show the HTT carried out its work to a high standard.**

### 3.4 Home treatment teams clinical reviews and handovers

An interviewee told us the HTT usually cared for 20-30 patients but this had risen to 40-43 in previous months. The interim team manager told us this increase might have been due to the pressure on inpatient beds. The HTT service operates from 08.00 to 22.00, seven days a week. Staff work shifts and the shift coordinator allocates which patients they visit.

We found 10 HTT staff members had visited or contacted Mr. S, so we asked staff how they kept each other informed of a client's care and how it was reviewed.

The team manager explained how staff discussed cases:

> *"The afternoon shift come on at 2 and then the early shift finishes at 4 so within that two hours you would have a handover."*

The team consultant, team doctor, team manager and an HTT worker also attend a weekly clinical review meeting. The team manager told us:

> *"…we will get staff from that shift and do a ward round. Where we can then go through the board and we can look at things like risk assessment, quality of risk assessments, clustering and that the clustering has been done. Whether an ICD10 code is there, quality of the handovers. So it gives us a more … it's less pressure than that 2 hours…"*

***Comment***

***This combination of daily handover and weekly clinical review seems an appropriate means of ensuring care provided is meeting a client's needs.***

### 3.5 Consistency of visiting staff

Mr. S GP referred Mr. S to the ABT. Mr. S was not previously known to the Trust mental health services so they did not, for example, have a care coordinator who knew him. We asked staff how they developed a therapeutic relationship with Mr. S, with so many people visiting him. The interim manager, who was an HTT team leader when Mr. S was in their care, told us:

> *"I mean you've hit it on the head really which is what service users, whenever we've done surveys, always say you know, home treatment's helpful but actually all these different workers doesn't help. The difficulty we have on the ground is that we have a shift in place, shifts are managed by e-rostering. We do attempt to try and limit the amount of workers but it's difficult,* ***we have been given an internal target because of what you've just raised to say that we should attempt to try and keep it to four workers that's one of our internal targets*** *to a model we should be looking at."*

A nurse who visited Mr. S told us:

> *"I mean very often you are reliant on what someone else has told you, what you've read in the notes and then you go for your visit. And then you might not see the person for another few, I mean I personally would like to see individuals…. We'd really like to be able to do that but it's difficult because we know that people want to build a rapport, they like certain members of staff better than others, that's human nature. And sometimes it is such a small piece of work we do. So I mean people don't want lots of different people going into their house either."*

Another nurse who visited Mr. S reinforced this:

> *"That would be better for the client yes. And I think the makeup of the HTT, you know, it puts, you know, in a very difficult position because it's whoever is on shift, yes. But I think there has been consistency in terms of some people going to see him more than others."*

We do not know if the internal target of limiting visits to four different workers was in place at the time Mr. S was with the HTT, but having ten different staff visit or contact him may have made it difficult to develop a therapeutic relationship with him. We asked staff if allocating a key worker to an individual to oversee interventions would have been helpful and they supported this.

***Comment***

***A large number of different staff visiting one service user is a risk factor but we do not believe it compromised HTT's care of Mr. S. Allocating a maximum of four different staff to a case is helpful. There may also be an advantage in allocating a key worker to a case.***

**Recommendation 1**

**The Trust should put in place processes to ensure that the number of different staff visiting individuals from a HTT is limited to as few as possible. This should be prioritised for those clients new to the service. The Trust should also evaluate whether allocating a key worker to oversee a case would be helpful.**

### 3.6 Was it appropriate for the HTT to transfer Mr. S care back to the ABT?

HTT workers recorded that Mr. S mental state was improving after 11 February. The consultant psychiatrist reviewed him on 25 February. Mr. S wife was present. The records show Mr. S wife said Mr. S had improved since starting medication, was doing more at home and was engaging better with their daughter.

An HTT worker also visited Mr. S on 25 February. He noted Mr. S mental state was better and agreed to discharge him from the HTT on 28 February 2013.

A CPN made another visit on 28 February at 12.15 and recorded the following:

> *"[Mr. S] was dressed in his pyjamas. Good self-care observed. Had good eye contact. Described his mood as much better. Mood objectively better. Affect: Reactive. Reported to be feeling less anxious. No psychotic symptoms elicited. Reported to be sleeping better on promethazine. Eating well. (Mr. S) reported that he has been keeping himself busy helping with cooking. No suicidal thoughts reported upon direct questioning.*
>
> *Plan: discharge from HTT today. To be followed up by ABT. Crisis card given for [Mr. S] to access support in the event of a crisis. 2 weeks supply of TTA medication was given on discharge. Copy of the discharge plan to faxed to GP, Mill House and posted to [Mr. S]."*

The HTT chose to discharge Mr. S to the ABT because of his suicidal thoughts and continuing anxiety. They chose not to discharge him back to his GP.

**Finding 4**

**It was appropriate for the HTT to transfer Mr. S care back to the ABT.**

### 3.7 Joint visits

The HTT referred Mr. S to the ABT duty team using a discharge referral form. Mr. S did not engage with the ABT team other than to cancel his appointments for April and May. We therefore asked interviewees whether joint visits when

transferring individuals to other teams would help to increase the likelihood of clients engaging with teams. Interviewees told us this would be helpful in some cases and in particular when someone similar to Mr. S is transferred to a team that has had no previous contact with a client other than an initial assessment. In other cases we were told a joint visit would not be necessary, for example, when someone is transferred back to a team they are familiar with, such as the recovery team.

***Comment***

***A joint visit between the HTT and ABT staff when Mr. S care was handed over may have helped him engage more with ABT, but we cannot be certain.***

An undated H HTT operational policy says:

> *"Where HTT is discharging to another secondary care team, continuing medical responsibility is transferred to the Consultant in that team, with discussion with the GP. A joint visit / 'closure' handover with the involved professional is always preferable."*

The interim manager of the HTT told us:

> *"With ABT they currently don't have the resources to do joint visits…. Mr. S was under our care we would do the referral to them have the discussion on the phone and then they would take up the case when we discharged."*

The ABT consultant psychiatrist allocated to Mr. S told us joint visits "*doesn't happen often enough*".

The ABT team manager told us there was a significant issue with capacity because they did not anticipate the number of assessments they needed to conduct. This was particularly an issue with referrals from clients unknown to the service. They lacked the resources to make joint visits.

**Recommendation 2**

**Where it is clinically indicated joint visits between H ABT and the HTT should take place. This is to increase the likelihood of clients engaging and improving continuity of care, in particular for clients who were previously unknown to Trust services.**

### 3.8 ABT second involvement

The ABT sent a letter on 8 March 2013 inviting Mr. S to attend an outpatient's appointment with one of the team consultant psychiatrists on 16 April. Mr. S cancelled the appointment and was given a new appointment for 27 June. The ABT moved it to 1 July. Mr. S did not attend that appointment and the team consultant discharged him back to the care of his GP on 18 July.

We examined if the discharge from ABT was appropriate and carried out with due care.

The team consultant tried to call Mr. S on 1 July because he had not attended his appointment that day. The consultant also called the next day without success. He told us he would normally call the GP to confirm he had the right phone number but could not remember if he did on this occasion.

The notes from 5 July 2013 show the team consultant psychiatrist reviewed Mr. S notes. He decided to refer the patient back to his GP because he was stable when the HTT discharged him.

Our review of the notes and interviews shows the decision to refer Mr. S back to his GP was a considered one. The consultant psychiatrist knew Mr. S wife was supporting him. Mr. S had been given a crisis card and was in contact with his GP. The consultant psychiatrist had identified no continuing risks of suicide on discharge from the HTT and there was never a suggestion a homicide would occur.

**Finding 5**

**Based on the information available to the ABT psychiatrist and the actions he took to contact Mr. S and review his notes, discharging him back to the care of his GP was appropriate.**

### 3.9 Intervals between outpatient appointments

We asked the ABT consultant psychiatrist how he decided the interval between appointments for Mr. S. He told us:

> *"… When we are thinking about making, doing a triage the quickest way to consider the follow up appointments is really to think about having either an urgent appointment or a routine appointment. If it's urgent then of course the clinician would make it there and then."*

He told us Mr. S fell into the category of routine appointments based on information he received at Mr. S referral. This meant his appointments with Mr. S would take place about every eight weeks. We asked the consultant about his case load and he said he was the lead professional for just under 170 clients, though a few clients may also have been receiving CBT.

The ABT manager told that consultant caseloads had been reviewed and reduced in recent months. However, there were no available slots with a consultant until the New Year (as at 7 October 2013).

We considered whether the size of the consultant's caseload had bearing on this case. The consultant psychiatrist had offered Mr. S an appointment about a month after his referral from the HTT, which Mr. S cancelled. He offered Mr. S more appointments and tried to contact him. The consultant followed Mr. S up properly despite his caseload pressure and made a risk assessment before discharging him back to the GP.

***Comment***

***Despite the actions taken by the consultant to follow up the patient we believe a caseload of just under 170 clients is probably excessive and the clinical director should review this with the consultant.***

**Recommendation 3**

**The clinical director should review the size of caseloads with H ABT consultants to ensure they have time to offer priority appointments and appropriate intervals between routine appointments.**

### 3.10 Psychological assessment

The consultant psychiatrist saw Mr. S on 25 February and referred him for cognitive behavioural therapy (CBT). A referral letter was sent on 26 February.

The psychology service sent Mr. S an appointment for 23 April but he did not make contact or respond to their follow-up letter. The service therefore referred him back to the consultant psychiatrist on 13 May.

**Finding 6**

**The referral of Mr. S for CBT was appropriate and psychology service's response was timely.**

### 3.11 Did Mr. S wife need carer support and should Mr. S have been referred to the Trust safeguarding lead?

We explored if there were safeguarding issues that would have made a safeguarding referral necessary. Several interviewees said Mr. S marriage was good and they had not identified concerns relating to the care of Mr. S child. The HTT consultant psychiatrist told us:

> *"And I just think he was a man that didn't, wasn't, didn't talk about his feelings. You know, got on and did things and had been very well functioning and now in this crisis seemed to close up on himself but that it wasn't an inherent part of their relationship and it wasn't an ongoing problem for their relationship. But he, you know, he wasn't somebody who was disengaged from his family. I mean when he was well he shared in the childcare arrangements, he cooked, he'd tell you, he said to me, "I really love cooking so I do a lot of the cooking and we have friends over." So, you know, they seemed to be a very loving couple that did a lot of things together."*

A member of the nursing staff told us that when she visited Mr. S home:

> *"There was no concern. Every time I went to visit it was like they were very relaxed, talking to each other. The wife was very supportive, she was willing to support, you know, it's like … And even with the baby, you*

*know, she was very caring even with us at the time I'd go, you know, she would offer a cup of tea. Very nice lady, very welcoming."*

The records also show Mr. S mother was coming over from India to help the family.

***Comment***

***We found that safeguarding had been considered and there was no evidence to make a referral to the trust adult or children's safeguarding leads. Mr. S wife had been seen on her own by HTT workers and a carer's assessment was not indicated.***

### 3.12 Should cultural-ethnic issues have been taken into account?

Mr. S came from India and his wife was of Indian heritage but was born in this country.

We could not identify cultural-ethnic issues affecting this case. Staff did not mention language problems or religious issues with Mr. S when we interviewed nor did we find reference to such issues in the notes.

### 3.13 Involvement of GP

We interviewed the patient's GP who gave us the relevant information he had on Mr. S care. He had reviewed the notes and the practice had carried out a critical incident review before we met. The review showed no difficulties with communication between the Trust and Mr. S or the GP's practice.

The GP told us:

*"I referred him urgently, with a faxed letter, to Mill House saying that he needs to be assessed today because he's actively suicidal. I received a fax, I don't know what time I referred him but I certainly received a fax, according to records, at 12.49 from Mill House. It was saying that a senior member of the clinical team would review the referral I just sent and he would be dealt with in due course. That was my first dealing with him."*

"*After receiving the fax I received an admission discharge summary saying that he was admitted on the 25th and discharged on the 27th. That the ABT Team was to see him on a daily basis and then to reduce the visits on alternate days as his mental state improved. That was the discharge I received."*

We could not tell from the records which discharge summary the GP meant because the only one we found on record was the discharge summary from HTT to ABT. We found a CRT/A&E liaison team care plan, which says HTT was to follow Mr. S up. The GP told us:

*"There haven't been any problems with the services. He was seen immediately. I got a letter, a fax, saying the referral letter had been*

*received. It was a very good safety net I suppose. That's actually a very good practice to get a letter saying that my referral has been received and is being acted upon. That was reassuring."*

ABT staff told us that GPs were confused about the roles of different teams. They also said they had been unable to link with GPs in the way they could before because they now covered larger areas.

**Recommendation 4**

**The Trust should review GPs' understanding of the current team structures and service-line arrangements. If necessary they should put a communication strategy in place to improve GP's understanding.**

We asked Mr. S GP if the private psychiatrist was aware Mr. S was also seeing NHS services. He said:

*"No. There might have been at the beginning in his first assessment; I need to look at his letters but there's no mention about whether he should, or should not be, or whether he's not attended subsequently, no. (the private psychiatrist)…,more or less, took over his care on a regular basis."*

He also told us Mr. S did not mention his involvement with the NHS:

*"He only mentioned (the private psychiatrist)… and the private CBT. He didn't mention anything to me in the five consults I saw him about him having any follow-up with any of the NHS services."*

We asked the GP if he should have contacted the NHS about Mr. S involvement with the private psychiatrist. He told us:

*"Yes, I think sometimes it probably is the fault of our systems. Sometimes when we do get these letters – I knew that he was seeing people privately. Of course, if I had all the time in the world it would be courteous for me to have written to the NHS service and said actually are you aware that he's under (the private psychiatrist)… and having this; but that letter wasn't sent. Presumably, I thought he might have cancelled the appointments or he might have informed the CBT services through telephoning."*

The GP told us that when the patient came to the practice:

*"…he came to see one of my partners on 28 January with physical symptoms, left side chest pain, arm pain and leg pain. My partner had noted that he was, mentally, feeling stronger and he denied suicidal intent. Again the symptoms were so bizarre and because he had private health cover she referred him straightaway to see a consultant neurologist, Dr … whom he saw two days later. In the private sector you*

*can see them very quickly, Dr … assessed him and I noted in one of the sentences he summarised he 'wouldn't be surprised if he didn't find anything un-towards here and he urged Mr. S to continue seeking the consultant psychiatrist's help'. He was going to see (the private psychiatrist)… the following week. Obviously reading between the lines, Dr ….felt that this was, predominantly, psychiatric and not neurological. Nonetheless he still arranged some routine brain scans and things at the time."*

*"After that, the next time I saw him was 4 March but, between him being referred to see a neurologist on 30 January, he'd been assessed privately by (private psychiatrist)…, the consultant psychiatrist, who I must state that I feel is the main psychiatric person looking after him."*

Mr. S GP commented on Mr. S involvement with NHS services:

*"The bit that is a bit vague about his post-discharge follow-up is because we didn't receive any letters. If there are any lessons to be learnt it would be lovely to have received a short note from the brief intervention team follow up saying 'we saw Mr. S today and he's getting better etc.' There aren't any letters like that. He was probably having this daily and alternate day follow-up but because, I suppose, he was still under the remit of the secondary care, or whatever you would like to say, certainly we didn't get that information. Then, fair enough, we expect he's having the treatment but we only found out he hadn't attended, he was meant to be attending, when we got the DNA letters but by that time he's already in the private care sector."*

***Comment***

***The GP was confused about which team visited Mr. S daily, but his comment about receiving update letters is relevant.***

**Recommendation 5**

**The Trust should consider how GPs are kept up to date about the progress of clients they have referred. In particular, clients who are moving through a number of care pathways and being supported by different teams.**

The GP told us that, he was confused when he received a discharge form from the HTT about whether Mr. S had been admitted at some point. The form used for this is headed "Discharge Notification (Inpatient/HTT)" and was sent when Mr. S was transferred from HTT to ABT. It was accompanied with a CRT discharge summary plan, which set out the progress and interventions and agreed care plan and medication for Mr. S.

The discharge notification form and CRT summary plans do not make it clear that Mr. S was not being discharged but transferred to another team. One line in the CRT form says *"To be followed up by ABT".*

***Comment***

***One of the purposes of these forms is to keep the GP and others aware of what is happening to an individual. These forms fail to do this. Also the language used when a client is being transferred to other parts of the service is not consistent with the principle of care pathways across service lines.***

**Finding 7**

**The discharge notification (inpatient/HTT) form and the CRT discharge summary plan form need to be changed because they give the impression a client is being discharged from the service instead of being transferred between Trust services.**

**Recommendation 6**

**The Trust should amend the discharge notification (inpatient/HTT) form and the CRT discharge summary plan form to clearly indicate a client is being transferred between services and not being discharged.**

***Comment***

***We were impressed with the professionalism of Mr. S GP, in particular the effort he made to review his practice's involvement with Mr. S and the critical incident review they performed.***

### 3.14 Role of the private consultant and communication between him and the Trust

Trust records indicate Mr. S was seeing a private consultant psychiatrist while he was in the Trust's care. Based on our review of the records, we initially believed Mr. S had seen a private psychiatrist only once or twice. We interviewed Mr. S GP who gave us his chronology of Mr. S visits and the letters sent to him. It shows Mr. S was more involved with the private psychiatrist than Trust staff realised.

We wrote to Mr. S private consultant psychiatrist several times to ask for an interview. He told us he had sought advice from the Medical Protection Society and could not meet us without Mr. S consent.

We sent extracts of the draft report that were relevant to the involvement of private psychiatrist for comment. We received the following reply from the psychiatrist:

> *"By way of general comment, I would say that it is my usual practice to seek the consent of a patient in terms of my communication with GPs and other NHS doctors when seeing an individual privately. In the event of them not consenting, I would only pass on information if I could justify a breach of confidentiality."*

The private psychiatrist has not told us at any point whether he was aware of the Trust's involvement and if so whether he had sought Mr. S consent to liaise with the trust. Therefore the only information we have available on his involvement is what Mr. S GP supplied.

The GP did not give us copies of letters from the private psychiatrist because he did not have his permission. Instead, he summarised the contact the private psychiatrist had with Mr. S. We set out the GP's brief summary comments here because they provide some information that was not available to NHS staff about the range and content of the appointments.

> *"I [GP] saw him was 4 March but, between him being referred to see a neurologist on 30 January, he'd been assessed privately by Dr …, the [private] consultant psychiatrist, who I must state that I feel is the main psychiatric person looking after him."*
>
> *"He had two full appointments, 4th and 7th, where Dr … summarised in one letter, quite a long letter describing his background and a good psychiatric detailed history, about Mr. S. That was on 4 and 7 February."*
>
> *"He then saw Dr …, follow up, 18 February and 26 February where the letters were, basically, saying that he was having difficulty internalising feelings. That the pain was a bit less maybe and he was talking more about his feelings. When I saw him on 4 March he reported that he was feeling mentally better, his somatic symptoms were better and he was seeing Dr … regularly."*
>
> *"Then he saw Dr …again 16 and 25 March, less pain and increasing the dose of the pregabalin. Then he saw me on 26 March, saying 'generally better, more chatty, good insight and the CBT was helping'. At that time he was planning to have more CBT through a third psychological intervention through a CBT counsellor from his workplace."*
>
> *"He saw me on 11 April starting his CBT therapy, seeing the consultant and having CBT therapy and, overall, remaining fairly stable and able to express a few anger feelings. Then on 13 April he had two CBT sessions and apparently the second session, according to Dr …, was very cathartic. Then I received a DNA letter from the IAPT Team but that's, presumably, because he hadn't turned up to the follow-up because he'd been seeing Dr… and having the work with the CBT."*
>
> *"I saw him on 23 April and, at that time, I noted that he was getting anxious more about the circumstances of how his employers were treating him. He was getting very anxious and worked up that there was a potential threat of him being fired or they working up some case against him or something. I noted that he was due for his third CBT, at that time, the following Friday of the week of 23 April."*

*"Then Dr … saw him on 27 April. [He reported] The mood was variable, the pain was improving and then my last sight of the patient was on 2 May. Again, it was really a chat about all the problems he was having with the Human Resources team at his workplace and he felt that he was being bullied by them. He was being treated fairly unsympathetically, in his mind, about his illness and they were wondering whether he should be coming back and all that sort of stuff. That's the last I saw of him on 2 May and 4 May he saw Dr… where Dr… had reported his pain had, undoubtedly, improved and that's the last we had any consult."*

### 3.15 Medical liaison

Trust staff told us they thought Mr. S had seen a private psychiatrist only once. His HTT consultant psychiatrist told us:

*"I knew that he saw a private psychiatrist. When we first took him on for home treatment, I was on my own, my staff grade was on leave. So I was just doing half time with home treatment and trying to manage all the medical cover. When he was first taken I was only able to see him, I don't know, about four days later and he and his wife felt they couldn't wait and had to see a doctor, and therefore went to see a private psychiatrist. They were very upfront with that but my understanding, and I must have got it wrong or misinterpreted, but my understanding was when I saw him, was that it was a one off appointment and now that they had seen me, there was no reason to continue seeing the private psychiatrist. I was surprised to find out later that he'd still been seeing the private psychiatrist."*

We asked the HTT consultant psychiatrist what she would do if she knew a client was also seeing a private psychiatrist.

*"We'd have a discussion with Mr. S and that I'd have some kind of liaison with this private psychiatrist to say it's not ideal for a patient to be treated by two doctors. It isn't ideal and I mean, I would say to Mr. S I think that that's, it's very difficult to work like that and that their case either be led by me or was led by the private psychiatrist. We do have patients who've come from the private sector, and I do try to ensure that Mr. S has one person leading on their care."*

A review of the JADE notes show the HTT had recorded that the patient had seen a private psychiatrist more than once. This was recorded on the following dates:

- 8 February (at this meeting Mr. S told staff he had had his second session with the private psychiatrist);
- 13 February; and
- 18 February.

The GMC requires all medical staff (NHS or private) to communicate with each other if they are providing care to the same client. We do not know if the

private psychiatrist was aware that the NHS was involved with Mr. S. We know Mr. S told NHS staff about his appointments with the private psychiatrist.

The GMC's guidance on good medical practice set out below tries to ensure care is well coordinated.

> *"Continuity and coordination of care*
>
> 1. *44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:*
>
>     1. *a. share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers"*

***Comment***

***This extract from GMC guidance does not cover the issues of this case in detail but the principles in it are relevant.***

NHS staff did not try to contact the private psychiatrist although they knew he was seeing Mr. S. The GP's summary of the private psychiatrist's letters shows Mr. S had been referred for CBT. This may explain why Mr. S did not attend CBT when the HTT consultant psychiatrist referred him.

***Comment***

***Mr. S notes indicate that staff were aware that Mr. S had appointments with the private psychiatrist on a number of occasions. They could have tried to contact the psychiatrist but did not identify the need to do so in team handovers. This may have been due to the large number of staff visiting the patient.***

If we had interviewed the private psychiatrist we would have asked:

- whether he was aware of the NHS involvement with the patient;
- if he was aware of the NHS involvement were there consent or confidential issues stopping him from liaising;
- had he identified risks of possible suicide or homicide;
- whether he had interviewed the patient's wife and had he identified conflict or stress within their relationship; and
- what was the nature of the cathartic episode in CBT therapy.

**Recommendation 7**

**The Trust medical director and chief operating officer should issue guidance to Trust staff reminding them of the importance of communicating with non-Trust clinical staff who also provide care to their clients.**

**Recommendation 8**

**The Trust medical director should seek advice from the GMC on whether a private psychiatrist should cooperate as fully as possible with a Trust investigation.**

### 3.16 Post incident support

After a serious incident, the Trust requires support to be put in place for staff who may have been affected. The HTT team manager told us a psychologist led a debriefing meeting after the incident with Mr. S:

> *"…but nobody went to the debrief, well myself and [the team consultant]…went to the debrief but nobody else came down to the debrief. Staff feedback was that they didn't feel the need to attend…"*

She told us:

> *"Emails were sent out to staff, informing them, they were told of it on the day when it happened I went into the team room and said we have a psychologist that is doing the debrief on Mr. S but nobody wanted to go to it. They didn't feel affected by it."*

We concluded that the incident was still distressing several staff members. One of them had been on holiday when the debriefing meeting happened and was still upset and unclear if she had done anything wrong. Another member of staff still appeared distressed about the incident during their interview with us. Another member told us they had not been invited to the debrief.

We asked the team manager to let staff know at her next team meeting that support was still available.

**Finding 8**

**A single debriefing meeting is unlikely to be enough for staff because reactions to incidents can sometimes be delayed. Team managers should ensure team support is ongoing and staff are aware of it.**

**Recommendation 9**

**Senior Trust managers should ensure post incident support continues so that as many staff members as possible use it.**

## 4 Overall conclusion

Trust staff last saw the patient on 28 February. The HTT assessed he was suitable for discharge back to the ABT for follow up with outpatient appointments. Mr. S cancelled two offers of appointments with the ABT consultant in April and May. During this period he also failed to turn up for psychology appointments. He then failed to turn up for an appointment with the ABT consultant on 1 July. He had five appointments with his GP after NHS staff saw him, the last on 2 May. He also had six further appointments with the private psychiatrist who sent a report back to the GP dated 4 May.

The ABT consultant decided to close Mr. S case and refer him back to the GP on 5 July after he reviewed the information and risk factors. We believe this was an appropriate decision.

**Finding 9**

**Our review of the care of Mr. S shows HTT and ABT carried out their responsibilities with care and professionalism.**

## 5 Analysis, recommendations and distribution

### 5.1 Notable practice

The referral of the patient by his GP for CBT was appropriate and the psychology service's response was timely.

The frequency of visits, support provided and quality of notes made during Mr. S involvement with HTT met Mr. S needs and show the HTT carried out its work to a high standard.

We were impressed with the professionalism of Mr. S GP, in particular the effort he made to review his practice's involvement with Mr. S and the critical incident review they had carried out.

Our review of Mr. S care shows the HTT and the ABT carried out their responsibilities carefully and with a high standard of professionalism.

### 5.2 Care and service delivery problems

The discharge notification (inpatient/HTT) form and the CRT discharge summary plan form need to be changed because they give the impression a client is being discharged from the service instead of being transferred between Trust services.

A joint visit between the HTT and ABT staff when Mr. S care was handed over may have helped him engage more with ABT, but we cannot be certain.

There was a large number of different staff visiting Mr. S.

Mr. S was seeing a private psychiatrist more than once but this was not picked up in team handovers and therefore contact with him was not made.

### 5.3 Contributory factors

None identified

### 5.4 Root causes

None identified

### 5.5 Lessons learned

Allocating a maximum of four different staff to a case will be helpful. There may also be an advantage in allocating a key worker to a case.

### 5.6 Recommendations

**R1** The Trust should put in place processes to ensure that the number of different staff visiting individuals from a HTT is limited to as few as possible. This should be prioritised for those clients new to the service. The Trust should also evaluate whether allocating a key worker to oversee a case would be helpful.

**R2** Where it is clinically indicated joint visits between H ABT and the HTT should take place. This is to increase the likelihood of clients engaging and improving continuity of care, in particular for clients who were previously unknown to Trust services.

**R3** The clinical director should review the size of caseloads with H ABT consultants to ensure they have time to offer priority appointments and appropriate intervals between routine appointments.

**R4** The Trust should undertake a review of GPs understanding of the current team structures and service line arrangements and if needed put in place a communication strategy to improve their understanding.

**R5** The Trust should consider how GPs are kept up to date about the progress of clients they have referred. In particular, clients who are moving through a number of care pathways and being supported by different teams.

**R6** The Trust should amend the discharge notification (inpatient/HTT) form and the CRT discharge summary plan form to clearly indicate a client is being transferred between services and not being discharged.

**R7** The Trust medical director and chief operating officer should issue guidance to Trust staff to remind them of the importance of liaising with non-Trust clinical staff who are providing care/treatment to their clients.

**R8** The Trust medical director should seek advice from the GMC on whether a private psychiatrist should cooperate as fully as possible with a trust investigation.

**R9** Senior Trust managers should ensure post incident support continues so that as many staff members as possible use it.

| **Author** | Tariq Hussain | **Job title** | Senior Consultant, Verita | **Date** | 24-10-13 |
|---|---|---|---|---|---|

## 6 Action Plan:

| | Recommendations (repeat exactly as shown in the report) |
|---|---|
| 1 | The Trust should put in place processes that will ensure that the number of different staff visiting individuals from a HTT is limited to as few as possible. This should be prioritised for those clients new to the service. The Trust should also evaluate whether allocating a key worker to oversee a case would be helpful. |
| 2 | Where it is clinically indicated joint visits between H ABT and the HTT should take place. This is to increase the likelihood of clients engaging and improving continuity of care, in particular for clients who were previously unknown to Trust services. |
| 3 | The clinical director should review the size of caseloads with H ABT consultants to ensure they have time to offer priority appointments and appropriate intervals between routine appointments. |
| 4 | The Trust should undertake a review of GP's understanding of the current team structures and service line arrangements and if needed put in place a communication strategy to improve their understanding. |
| 5 | The Trust should consider how GPs are kept up to date about the progress of clients they have referred. In particular, clients who are moving through a number of care pathways and being supported by different teams. |
| 6 | The Trust should amend the discharge notification (inpatient/HTT) form and the CRT discharge summary plan form to clearly indicate a client is being transferred between services and not being discharged. |
| 7 | The Trust medical director and chief operating officer should issue guidance to Trust staff to remind them of the importance of liaising with non-Trust clinical staff who are providing care/treatment to their clients. |
| 8 | The Trust medical director should seek advice from the GMC on whether a private psychiatrist should cooperate as fully as possible with a trust investigation. |
| 9 | Senior Trust managers should ensure post incident support continues so that as many staff members as possible use it. |

| Rec No | *Action*<br>What action is needed to achieve recommendation? | What will be relied on as evidence of implementation? (1) | Who by? (post not name) | When? | *Progress / completion*<br>Action taken (embed evidence) to implement recommendation (2) | Date |
|---|---|---|---|---|---|---|
| **Fixed** | To provide feedback to the patient / relatives and to relevant staff on the findings of the investigation. | Details of the arrangements for ensuring information is provided to relatives and staff. | Service Directors, ABT and Acute | 31st Nov 2013 | | |
| **1** | The Acute Service is currently reviewing the Home Treatment Team Operational Policy. This is being achieved by each of the 5 HTT Managers leading on work streams to develop key areas, which will inform the final Operational Policy. | Each HTT Manager is responsible for reviewing key aspects of the HTT care pathway.<br>Progress so far will be discussed in the HTT Forum November 2013 and the Operational Policy finalised by 31st December 2013. | HTT Managers | 31st Dec 2013 | Evidence of the implementation of this action. | |
| | This includes the target to support all patients under the care of an HTT being seen where possible by a maximum of 4 members of staff during an episode of care (this is to support patients under the care of HTTs being seen by 2 members of staff 80% of the time during the episode of care). A criteria is in the process of being developed to identify those patients who would particularly benefit from this-for example those patients who are new to the service, are difficult to engage and who are perceived to be a high risk to self or others. | The revised HTT Operational Policy will then be disseminated to the HTT. The revised policy contains New Ways of Working, which will be evaluated from January 2013.<br>A column will added to each HTT's patient information board to support the tracking of the number of staff involved with each patient.<br>The number of HTT staff involved with each patient will then be monitored by a monthly audit to be submitted to the Acute Service Clinical Audit Facilitator by each Team Manager on a monthly basis commencing January 2014. | Business and Service Improvement Manager, Service Director, Lead Nurse | 31st Dec 2013 | | |
| | The HTTs are also in the process of exploring whether the use of electronic rostering (currently used in Inpatient Wards) will support more effective HTT staff rotas. E-rostering is currently in use in H's HTT only. | | | | Current description-under review as described. | |
| | The revised HTT Operational Policy will be circulated to the HTT Forum for comments at the end of November and will be ratified by 31st December 2013 | A criteria outlining the role of the Crisis/Key Worker will be incorporated into the revised HTT | HTT Managers Service Director Lead Nurse | 31st Dec 2013 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | prior to dissemination to all HTT staff.<br><br>Currently each team as stated in the current HTT Operational Policy allocates a Crisis/Key Worker to each patient at the start of an episode of care.<br>This role is key to providing a consistent approach in relation to for example updating risk assessments and liaising with other agencies, the GP.<br>The role of the Crisis/Key Worker is under review and will be included in the revised Operational Policy | Operational Policy-evidence-the Revised Operational Policy<br>To support the dissemination of the revised HTT Operational Policy presentations will be arranged for each HTT-to ensure that all have a clear understanding of the HTT New Ways of Working as outlined in the Policy-evidence:<br>-Presentation-power point<br>-email to each HTT outlining date and time of presentations<br>-minutes and attendance. | HTT Managers Service Managers (each site) | | | |
| **2** | At the point of transfer between ABT and HTT, a joint home visit should be made by a member of each team where possible<br><br>Alter the operational policies of both teams to reflect this piece of good practice | Amended operational policies<br><br>Audit of implementation | ABT and HTT Managers<br><br>ABT and HTT Managers and Trust Audit Department | End January 2014<br><br>End March 2014 | | |
| **3** | Review caseloads of H ABT Consultants, implementing measures to reduce them if appropriate | Written account of review and outcome of review | ABT Clinical Director | End December 2013 | | |
| **4** | Review H GPs' understanding of current service line structure.<br><br>If needed, implement communications strategy to inform GPs of current structure | Survey of H GPs<br><br>Evidence of communication to GPs | H ABT Service Manager<br><br>H ABT Service Manager | End December 2013<br><br>End January 2014 | | |
| **5** | Improve communication from Trust to GPs when patients move between service lines | ABT, Acute and Psychological Medicine Service Lines to discuss and agree more timely communication when patients move between service lines | Clinical Directors of ABT, Acute and Psychological Medicine Service Lines | End January 2014 | | |
| **6** | Need to review and amend the current | Discussion at Acute Care Quality | Clinical Director | End | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | HTT discharge notification form to indicate whether the patient is either discharged back to primary care or transferred to another service in secondary care.<br>The CRT form is only used in H. This form needs to be amended to indicate whether Mr. S is discharged back to primary care or transferred within the service. | and Innovation Group.<br>Discussion at HTT Forum.<br>Form to be amended and JADE change request form sent to HQ Jade Team for action. | and Lead Nurse, Acute Service Line. | Feb 14 | | |
| **7** | Instruct clinical staff to communicate with non-NHS mental health professionals working with clients | Letter from Chief Operating Officer and Medical Director to all clinical staff in CNWL's mental health services | Chief Operating Officer/Medical Director | End November 2013 | | |
| **8** | Ask GMC if a private psychiatrist is expected to participate in a root cause analysis in a different organisation when a serious incident has taken place | Letter from Trust Medical Director to GMC | Medical Director | End November 2013 | | |
| **9** | Offer emotional/psychological support to clinical staff involved with this case continues as long as it is needed. | Letter to staff of H ABT and HT teams | ABT and Acute Service Directors | End November 2013 | | |

Action Plan agreed by
Service / Clinical Director: ______________________*(print name)* Signed:_________________________ Date: ________________

## Notes

(1) Describe the evidence that <u>will</u> provide assurance of effective implementation of the action.

(2) Indicate whether this is a progress report or whether the action is completed. Embed electronic copy of relevant documents that was relied upon as evidence of effective implementation.